Signature Eye Care New Patient Registration

First Name: _____ Last Name: _____ Preferred Name: _____

Birth Date: _____ SSN (last 4): _____ Sex: M / F Marital Status: ☐ Single ☐ Married ☐ Other

Address: _____City/State/Zip: _____

Email address: _____

Phone number: _____ ☐ Home ☐ Cell (Do you prefer text messages? ☐ Yes ☐ No)

What is your occupation? _____

When was your last eye exam? _____ Eye Doctor & Location: _____

Primary Care Doctor: _____ Practice Name & Location: _____

How Did You Hear About Us?

How did you hear about our office? ☐ Family ☐ Friend ☐ Online ☐ Insurance List ☐ Facebook ☐ Signage ☐ Other _____

If family or friend, who may we thank for your referral? _____

Insurance Information

Primary Medical Insurance: _____Card Holder's Name/Date of Birth: _____

Vision Insurance: _____Card Holder's Name/Date of Birth: _____

Glasses and Contacts

Do you currently wear glasses? ☐ Yes ☐ No Lens Type: ☐ Single vision ☐ No-line (Progressive) ☐ Bifocal ☐ Trifocal

Do you wear sunglasses when outdoors? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Eye History

Check any that apply:

☐ Blurred/Loss of vision	☐ Eye pain/soreness	☐ Dry eyes	☐ Amblyopia (lazy eye)
☐ Double vision	☐ Watery eyes	☐ Red eyes	☐ Cataract
☐ Floaters	☐ Sandy/gritty feeling	☐ Burning/Itching	☐ Retinal problems
☐ Crossed eyes	☐ Glare/Light sensitivity	☐ Eye surgery	☐ Macular degeneration
☐ Flashes of light	☐ Tired eyes	☐ Glaucoma	☐ Strabismus (eye turn)

☐ Other: _____

Social History

Do you smoke? ☐ Yes ☐ No If yes, type: ☐ Tobacco Products ☐ Marijuana

Do you consume alcohol? ☐ Yes ☐ No If yes, amount: _____

Medical History (Check all that apply)

Ear/Nose/Mouth/Throat
- ▢ Hearing loss
- ▢ Sinusitis
- ▢ Dry mouth
- ▢ Allergies

Neurological
- ▢ Multiple Sclerosis
- ▢ Epilepsy
- ▢ Tumor
- ▢ Migraine

Skin
- ▢ Eczema
- ▢ Rosacea
- ▢ Psoriasis
- ▢ Cold sores
- ▢ Shingles

Psychiatric
- ▢ Depression
- ▢ Anxiety disorder
- ▢ Attention deficit
- ▢ Bipolar disorder

Cardiovascular
- ▢ High blood pressure
- ▢ Stroke
- ▢ Heart disease
- ▢ Vascular disease
- ▢ Congestive heart failure

Endocrine
- ▢ Type 1 diabetes
- ▢ Type 2 diabetes
- ▢ Thyroid dysfunction
- ▢ Hormonal dysfunction

Gastrointestinal
- ▢ Crohn's disease
- ▢ Colitis
- ▢ Ulcer
- ▢ Kidney disease
- ▢ Acid reflux
- ▢ Celiac disease

Musculoskeletal
- ▢ Arthritis
- ▢ Gout
- ▢ Fibromyalgia
- ▢ Muscular dystrophy
- ▢ Ankylosis spondylitis

Constitutional
- ▢ Developmental disability
- ▢ Cancer

Blood/Lymph
- ▢ Anemia
- ▢ Ulcer
- ▢ High cholesterol

Genitourinary
- ▢ Prostate disease
- ▢ STD
- ▢ HIV
- ▢ Hepatitis

Respiratory
- ▢ Asthma
- ▢ Bronchitis
- ▢ Emphysema
- ▢ COPD
- ▢ Sleep apnea

▢ Other: _____

Are you currently pregnant? ▢ Yes ▢ No ▢ Not applicable

Medications and Allergies

Are you taking any medications? (including eye drops): ▢ No ▢ Yes, please list _____

_____

Do you have any allergies to Medications? ▢ No ▢ Yes, please list

_____

Family History

Check any that apply to your immediate family members (Ex: parents, siblings or children)

▢ Diabetes: _____ ▢ High blood pressure: _____ ▢ Cancer: _____ ▢ Thyroid: _____ ▢ Other: _____

▢ Cataracts: _____ ▢ Macular degeneration: _____ ▢ Glaucoma: _____ ▢ Strabismus: _____ ▢ None

Office Policy Agreement

AUTHORIZATION TO RELEASE INFORMATION: I authorize Signature Eye Care to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I authorize Signature Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.

PAYMENT POLICY: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed and it is my responsibility to pay any deductible, refraction, copay or other balances not paid by my insurance company. I authorize insurance benefits to be paid directly to Signature Eye Care. Effective from today's visit and all future visits.

VISION PLAN COVERAGE: I understand that only one vision plan may be used for exam/materials per visit-per patient. The plan to be used must be chosen before the exam occurs.

COMMUNICATION AGREEMENT: I authorize Signature Eye Care to communicate with myself and authorized individuals via the email I provided for today's visit and all future visits. The purposes can include but are not limited to appointment reminders, attachments of itemized receipts, glasses and/or contact lens prescriptions, and newsletters.

MEDICAL BILLING: I understand that if I am being seen for a medical condition that can affect my eye health or vision (examples include but are not limited to diabetes, cataracts, glaucoma ect) my medical insurance will be billed first. If I have a vision insurance, we will coordinate if possible.

_____ _____

Patient or Guardian Signature: Date: