# Eye Care Registration and History

## Patient Information

Patient Name: Date:

Address: City, State, Zip:

Home Phone#: Cell#: Work#:

Sex: M F Age: Birth date: SS#:

Are you?: Married Single Minor Other (please circle one)

Patient's Employer: Occupation:

Spouse's Name: Birth date: SS#:

Other than your spouse, who may we contact in case of emergency?

## Insurance Information

Subscribers Name:

SS#: Subscribers Birth date:

Relationship to patient: Self Spouse Parent

Insurance Company: Subscriber ID#:

My fees and co-payments will be paid by: CASH / CHECK / CREDIT CARD {circle one}

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with_____ and assign directly to Granite City Vision all insurance benefits. If any, otherwise payable to me for services rendered, I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions on all insurance listed as well as Medicare and Medicaid.

The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

**Signature:**_____

## Eye Health History

Do you currently wear glasses? YES NO Contacts? YES NO Brand?:

{Please circle any of the following that affect your eyes}

| | | | |
|---|---|---|---|
| Blood shot eyes | Double Vision | Itchy Eyes | Twitching Eyelid |
| Blurred Vision- Distance | Dry Eyes | Light Sensitive | Vision Poor |
| Blurred Vision- Near | Eye Infection | Loss of Vision | Watery Eyes |
| Burning Eyes | Eye Injury | Migraines | |
| Cataracts | Eye Strain | Night Vision-Poor | |
| Color Vision, Poor | Fainting Spells, Blackout | Red Eyes | |
| Crossed Eyes | Floaters/ Spots | Seeing Halos | |
| Discharge from eyes | Glaucoma | Seeing Flashes | |
| Dizzy Spells | Headaches | Temporary Loss of Vision | |

## Health History

{Circle any of the following issues for yourself or family history. Leave blank if they do not apply.}

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | Yourself or Family | Hepatitis (type_____) | Yourself or Family | Are you pregnant? | Yes No |
| Arthritis | Yourself or Family | High Blood Pressure | Yourself or Family | Tobacco Use? | Yes No |
| Art. Heart Valve | Yourself or Family | Kidney Disease | Yourself or Family | | |
| Artificial Joints | Yourself or Family | Lazy Eye | Yourself or Family | | |
| Bleeding | Yourself or Family | Lupus | Yourself or Family | List any medications you a | |
| Blindness | Yourself or Family | Pacemaker | Yourself or Family | are currently taking: | |
| Cancer | Yourself or Family | Retinal Disease | Yourself or Family | _____ | |
| Cataracts | Yourself or Family | Rheumatic Fever | Yourself or Family | _____ | |
| Chemically Dept. | Yourself or Family | Shingles | Yourself or Family | _____ | |
| Diabetes | Yourself or Family | Skin Conditions | Yourself or Family | Please list any allergies | |
| Drug Sensitive | Yourself or Family | Stroke | Yourself or Family | to medication: | |
| Emphysema | Yourself or Family | Thyroid Conditions | Yourself or Family | _____ | |
| Eye Surgery | Yourself or Family | Tuberculosis | Yourself or Family | _____ | |
| Glaucoma | Yourself or Family | Turned Eye | Yourself or Family | _____ | |