CLIFTON EYE CARE

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐Dr. ☐Miss ☐Mr. ☐Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name _____

Address Line 1 _____ City, State _____ ZIP _____

Home Phone (____)_____ Cell No. (____)_____ Work Phone (____)_____ Ext. _____

Primary Care Provider (PCP)_____ Referring Provider_____

E-Mail Address: _____ Date of Birth MM_____/DD_____/YYYY_____ Sex ☐F-Female ☐M-Male ☐Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐Native Hawaiian or Other Pacific Islander ☐Black or African American ☐ White ☐Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐Korean ☐ French ☐German ☐ Russian ☐ Other _____

Marital Status ☐Married ☐ Single ☐Divorced ☐ Widowed ☐ Legally Separated ☐Partner

Social Security Number _____-____-_____ Employer Name _____

Employment Status ☐1-Full-Time ☐2-Part-Time ☐3-Not Employed ☐4-Self-Employed ☐ 5-Retired ☐ 6-Active Military

Student Status ☐ F-Full-Time Student ☐P-Part-Time Student ☐ N-Not a Student

Emergency Contact: Last name _____ First Name _____

Phone Number (____)_____

Emergency Contact Relationship to Patient _____ ☐ Guardian

Address Line 1 _____ City, State _____ ZIP _____

Home Phone (____)_____ Work Phone (____)_____ Ext. _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐Self

Check here if information is same as patient☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM_____/DD_____/YYYY_____

Social Security Number _____-_____-_____ Telephone _____

E-Mail Address _____ Sex ☐ F-Female ☐ M-Male

Address Line 1 _____ City, State _____ ZIP _____

Employer _____ Employer Phone Number (____)_____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company _____ Phone Number (____) _____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Co-pay Amount _____

Effective Date _____ Subscriber Date of Birth MM_____/DD_____/YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date_____

Chart#_____ **MEDICAL QUESTIONNAIRE / EYE HISTORY** **Page#_____**

NAME: _____ Birth Date _____ (Month) / _____ (Day) / _____ (Year) Age _____

PRESENT EYE HISTORY: Chief eye complain? _____

Duration of this problem? _____ Chronic? ☐ YES ☐ NO Progressive? ☐ YES ☐ NO

Check or mark with an **X** if you have any of these **Eye Symptoms**:

Black Spots ___ Light Flashes ___ Shadows ___ Loss of Vision ___ Blurred Vision ___ Distorted Vision (Halos) ___ Loss of Side Vision ___ Double Vision ___ Headaches ___ Fluctuating Visual Acuity ___ Dryness ___ Eye Discharge ___ Redness ___ Itching ___ Sandy or Gritty Feeling ___ Sinusitis ___ Burning ___ Foreign Body Sensation ___ Tearing ___ Tired Eyes ___ Glare/Light Sensitivity ___ Eye Pain ___ Sties, Cyst, Lumps ___

If you marked an X, please explain (How long, etc) _____

PAST EYE HISTORY: Date last eye exam? _____ Where or Eye Doctor? _____

Do you wear glasses? _____ If YES, last time changed? _____ Are you considering contact lenses? _____
Do you wear contact lenses? _____ If YES, last time changed? _____ Daily wear? _____ Extended wear? _____ Color lenses? ___
Any Eye Diseases? _____ If YES, name? _____ Cataracts? _____ Glaucoma? _____ Infections? _____ Allergies? _____

Any Eye Surgeries? _____ If YES, type of surgery, when, where, surgeon? _____

_____

Do you use Eye medications? If So, which ones? _____

MEDICAL AND SOCIAL HISTORY: Name of Primary Physician _____ Location _____

Do you Smoke? YES ___ NO ___ Drink Alcohol? YES ___ NO ___ Occupation: _____ Student? YES ___ NO ___

List ALL Systemic Medications presently taking (Diet pills) _____

Allergies? _____

Other General Surgery or Illness or Hospitalization? _____

_____
Who in your family has had: Diabetes-Cataracts-Glaucoma-Blindness-Macular Degeneration-Hypertension-Heart Attack-Stroke-Cancer-Other

FAMILY HISTORY: _____

REVIEW OF SYSTEMS: Mark with an X if you have any of the following:

Fever ___ Weight loss ___ Gain Weight ___ Fatigue ___ Muscle Aches ___ Joint pain ___ Joint swelling ___ Arthritis ___ Hearing loss ___ Noises Tinnitus ___ Earaches ___ Sinuses ___ Teeth/Gum problems ___ Eczema ___ Psoriasis ___ Skin Rashes ___ Heart Attack ___ Palpitations ___ Chest Pain ___ Diabetes ___ Thyroid ___ High Blood Pressure ___ Aneurysm ___ Clots ___ Bruising ___ Low blood count ___ Asthma ___ Emphysema ___ Wheezing ___ Cough ___ Numbness ___ Weakness ___ Paralysis ___ Stomach/Duodenal/Ulcers ___ Heartburn ___ Constipation ___ Depression ___ Anxiety ___ Kidney Stones ___ Bladder/Prostate problems ___ Urination problems ___

If you marked an X, please explain: _____

How long and if receiving treatment: _____

_____Reviewed from _____ / _____ / _____ visit. Changes Noted: YES ___ NO ___

CHECKED BY _____ (INI) _____, M.D. Date _____

Reviewed by

Doctor: ____ Stegman, ____ Purewal, ____ Salzano, ____ Chechik, ____ Tannen, ____ Icasiano, ____Burrows, ____Frempong, ____ Cuttler, ____Ariola