ANEW VISION
EYE SPECIALISTS

Patient Registration Form

Patient name: _____ Date: _____

Date of birth: _____ SSN#: _____

Gender: M _____ F _____ Other_____

Marital Status: Married_____ Single_____ Widowed_____ Divorced_____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred: ☐Home ☐Cell

Email: _____

Race (optional): _____ Ethnicity (optional): Hispanic/Latino Y N

Employer _____ Work phone: _____

Emergency contact: _____ Phone number: _____

Relationship: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Location: _____

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Primary Insurance Information

Name of Insurance Company: _____

Effective Date: ___/_____/_____

Subscriber ID #: _____ Group #: _____

Policy Holder's Name: _____

Relation to patient: _____

Secondary Insurance Information

Name of Insurance Company: _____

Effective Date: ___/_____/_____

Subscriber ID #: _____ Group #:_____

Policy Holder's Name: _____

Relation to patient: _____

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Health History

Reason for your visit: _____

Ocular History

Current or Previous Eye problems (circle) or list: Diabetic Retinopathy

Dry Eyes Cataracts Glaucoma Macular Degeneration Retinal Detachment

Other:_____

Family History of (circle all that apply): Glaucoma Macular Degeneration Retinal Detachment

Eye Surgeries: _____

Do you wear (circle) glasses contact lenses both glasses and contacts

Last Eye Exam date: _____/_____/_____

Medications

List all medication you are currently taking (include dosage and frequency)

_____

_____

_____

_____

Eye Medications

LIst all eye drops you are currently taking (include frequency and which eye)

_____

_____

_____

_____

_____

Are you or have you ever been on any of the following medications (circle):

Plaquenil (hydroxychloroquine) Terazosin Prednisone

Mellaril (Thioridazine) Doxazosin

Tamoxifin Flomax (Tamsulosin)

Allergies: No Known Drug allergies

List all allergies to medications: _____

Social History

Do you or have you ever used alcohol? **Yes** **No**

Do you smoke currently? **Yes** **No**

how often?_____

Past Medical History

Place a mark on "yes" or "no" to indicate if you have a medical history of any of the following

Diabetes	**Yes**	**No**	**Type 1**	**Type 2**
Blood pressure	**Yes**	**No**		
Heart Disease/Heart Attat	**Yes**	**No**		
High Cholesterol	**Yes**	**No**		
Stroke	**Yes**	**No**		
Cancer	**Yes**	**No**		
HIV/AIDS	**Yes**	**No**		

Other:_____

Family History

Circle "Yes" or "No" to indicate if there is a history of any of the following in your family

Diabetes	**Yes**	**No**	**Who?**_____
Blood pressure	**Yes**	**No**	**Who?**_____
Heart Disease/Heart Attatck	**Yes**	**No**	**Who?**_____
High Cholesterol	**Yes**	**No**	**Who?**_____
Stroke	**Yes**	**No**	**Who?**_____
Cancer	**Yes**	**No**	**Who?**_____
HIV/AIDS	**Yes**	**No**	**Who?**_____
Other:_____	**Yes**	**No**	**Who?**_____