# Registration form for Optical Eyeworks

## Patient Information

Name * : _____

Date of Birth : ___/___/_____

Salutation : ___/___/_____

Street Address : _____

City : _____

State : _____

Zip : _____

Home Phone : _____

Mobile * : _____

Work Phone : _____

Email * : _____

## Vision Insurance Information

Please complete this so we may verify your benefits before your visit. Enter the insured person first name (primary member covered), date of birth and place of employment. You will need to look at your insurance card to complete this.

Insurance Company : _____

Insurance Member Name : _____

Member Date of Birth : ___/___/_____

Insurance ID : _____

Relationship to Patient * : _____

## Referral Information

Whom may we thank for referring you? Our "Share the Care" program offers substantial savings for referring friends and family.

Doctor Referral : _____

Patient Referral : _____

Internet Search : _____

| | | |
|---|---|---|
| Insurance Company | : | _____ |
| | | _____ |

# MEDICAL RECORDS

## Medications

| | | |
|---|---|---|
| Medication Name | : | _____ |
| Date Started | : | _____ |
| Use | : | _____ |

## Allergies

| | | |
|---|---|---|
| Name of Allergy | : | _____ |
| Reaction | : | _____ |
| Severity | : | _____ |
| Onset | : | _____ |
| Type | : | _____ |

## If Diabetic

| | | |
|---|---|---|
| When were you diagnosed as diabetic? | : | _____ |
| Blood Sugar | : | _____ |
| Date of Last Blood Sugar | : | _____ |
| Self Monitoring Blood Sugar | : | _____ |
| HbA1C | : | _____ |
| HbA1C Time | : | _____ |

## Ocular History

| | |
|---|---|
| Glaucoma | : _____ |
| Cataracts | : _____ |
| Macular Degeneration | : _____ |
| Eye Injury | : _____ |
| Retinal Disease | : _____ |
| Other Eye Disease | : _____ |
| Blindness/ Vision Loss | : _____ |
| Strabismus | : _____ |
| Amblyopia | : _____ |
| Ocular Complications Related to Diabetes | : _____ |
| Dry Eye | : _____ |
| Wear Glasses or Contacts | : _____ |
| Other | : _____ |

## Family History

| | |
|---|---|
| Family History of Glaucoma | : _____ |
| Cataracts | : _____ |
| Macular Degeneration | : _____ |
| Eye Injury | : _____ |
| Retina Disease | : _____ |
| Other Eye Disease | : _____ |
| Strabismus | : _____ |
| Amblyopia | : _____ |
| Blindness/ Vision Loss | : _____ |
| Diabetes | : _____ |
| Cancer | : _____ |
| Heart Disease | : _____ |
| Other Family History | : _____ |