FISHMAN & SHERIDAN eyeCare SPECIALISTS

PATIENT REGISTRATION INFORMATION

Patient's Name: _____ **Date:** _____

Home Phone: ( ) _____ **Cell:** ( ) _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: __/__/__ **Age:** _____ **Social Security Number:** ___-___-____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Widow(er)

Spouse / Partner Name: _____

Primary Health Insurance: _____

Secondary Health Insurance: _____

Name of Primary Insured: _____ **Date of Birth:** __/__/__

Employer: _____ **Phone:** ( ) _____

Refer Physician: _____ **Phone:** ( ) _____

Family Physician: _____ **Phone:** ( ) _____

Local Pharmacy: _____ **Phone:** ( ) _____

Mail Pharmacy: _____ **Phone:** ( ) _____

How did you hear about us?

- ❍ Magazine
- ❍ Movie Theater
- ❍ Newspaper
- ❍ Family or friend referral? Name: _____
- ❍ Physician referral? Name: _____
- ❍ Internet / Website
- ❍ Other: _____

Preferred method of contact:

❍ Home Phone ❍ Cell Phone/Text ❍ Work Phone ❍ E-mail

E-mail address: _____@_____.com

Emergency Contact Person

Name: _____ **Relationship** _____

Phone: ( ) _____

Medical History

OCULAR / VISION

Please mark any condition you have presently or have had in the past

- ☐ Dry Eyes ☐ Macular Degeneration ☐ Glaucoma
- ☐ Cataracts ☐ Retinal Detachment ☐ Keratoconus
- ☐ Others _____

Please mark any condition your family member or blood relative have presently or have had in the past, list relationship.

☐ Dry Eyes	_____	☐ Macular Degeneration	_____	☐ Glaucoma	_____
☐ Cataracts	_____	☐ Retinal Detachment	_____	☐ Keratoconus	_____
☐ Others	_____				

REVIEW OF SYSTEMS

Please mark any condition you or your family/blood relative have presently or have had in the past

	Self			Family			
	YES	**NO**		**YES**	**NO**		**FAMILY RELATIONSHIP**
High Blood Pressure	☐	☐		☐	☐		_____
Heart Problem	☐	☐		☐	☐		_____
Arthritis	☐	☐	❍ **RA** ❍ **OA**	☐	☐	❍ **RA** ❍ **OA**	_____
Lung Problems	☐	☐		☐	☐		_____
Stroke	☐	☐		☐	☐		_____
Thryroid Problems	☐	☐		☐	☐		_____
LDL	☐	☐		☐	☐		_____
Ulcers	☐	☐		☐	☐		_____
Cancer	☐	☐		☐	☐		_____
Diabetes	☐	☐		☐	☐		_____
❍ DM Type 1 ❍ DM Type 2 ❍ Diet ❍ NIDDM ❍ IDDM				❍ DM Type 1 ❍ DM Type 2 ❍ Diet ❍ NIDDM ❍ IDDM			

ALLERGIC/IMMUNOLOGIC & BLOOD/LYMPHATIC

- ☐ Seaonal Allergies
- ☐ Hay Fever
- ☐ Others _____

CONSTITUTIONAL & INTEGUMENTARY

- ☐ Fever
- ☐ Weight Loss
- ☐ Rash
- ☐ Skin Disease
- ☐ Others _____

GENITOURINARY

- ☐ Genital Ulcers
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Blood in Urine
- ☐ Others _____

NEUROLOGICAL PSYCHIATRY & MUSCULOSKELETAL

- ☐ Headache
- ☐ Migraines
- ☐ Paralysis Fever
- ☐ Joint Ache
- ☐ Others _____

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ Irregular Rhythm
- ☐ Other _____

GASTROINTESTINAL

- ☐ Vomiting
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Bloody Stools
- ☐ Other _____

HEAD / NECK

- ☐ Sinus Problems
- ☐ Post Nasal Drip
- ☐ Runny Nose
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Other _____

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Other _____

PREVIOUS SURGICAL HISTORY

Year of Surgery	Description/Type of Surgery

Social History

☐ Smoker ☐ Never Smoked

❍ Every day ❍ Some days ❍ Former Smoker ❍ Light Smoker ❍ Heavy Smoker

Type: ❍ Cigarettes ❍ Cigars ❍ Tobacco ❍ Other _____

How many years _____ Approx Start Date Approx End Date

FAMILY HISTORY OF SMOKING

☐ YES ☐ NO If Yes, please indicate who: _____

☐ Alcohol ☐ Never

❍ All ❍ Beer ❍ Spirits ❍ Wine ❍ Former Drinker

Frequency

_____ ❍ Per day ❍ Per Week ❍ Occasionally _____

List any NON presciption drugs

List any drug allergies

List ALL medications you are currently taking: (attach separate sheet if necessary)

By your signature below, you authorize us to bill your insurance company (if applicable) on your behalf for any covered services and agree to the release of medical information about you to your insurance company as necessary to process your claim.

Your signature below also confirms your agreement to pay for any ***non-covered*** and/or out of pocket responsibilities such as copays, coinsurance and deductibles at the time services are rendered.

PATIENT IS RESPONSIBLE TO VERIFY PROVIDER PARTICIPATION IN THEIR INSURANCE PLAN AND TO OBTAIN ANY REQUIRED INSURANCE AUTHORIZATIONS PRIOR TO THEIR VISIT.

_____ _____

Patient Signature Date

_____

Patient Guardian Signature