Patient Registration and History

Patient:_____
Last Name First Name Initial

Home Phone:_____ Cell:_____ Work: _____ Ext:____

Local Address:_____

City:_____ State:_____ Zip:_____

Email address: _____ Billing/Permanent Phone:_____

Billing/Permanent Address:_____

City:_____ State:_____ Zip:_____

Sex: M__ F___ Age_____ Birthdate:_____ Married ___Single___ Widowed ___ Separated____ Divorced____

Occupation:_____ Employer: _____

Emergency contact: _____ Phone: _____ Relationship:_____

Social Security #: _____

Referred by: _____ Phone: _____

Family Doctor: _____ Phone: _____

Eye Doctor: _____ Phone: _____

Reason for Visit: _____

Allergies to medicine: No____ Yes_____ Please list: _____

Current Medications/Vitamins:_____

Are you a smoker? (circle) Yes / No Ex-Smoker? Yes / No

How much are (were) you smoking? _____ How long ? _____ Quit how long ago? _____

How much alcohol do you drink? (circle) <1 drink/day 1 - 2 drinks/day >2 drinks/day

Please circle all of the following medical conditions you now have or have had in the past: high blood pressure / bleeding tendency / problems scarring or delayed healing / cancer / hepatitis / HIV / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / thyroid disease / depression / mental illness / drug or alcohol addiction / other _____

Is there any possibility that you might be pregnant at this time? Yes / No

List all surgeries that you have had (include plastic surgery) _____

_____

_____

I agree that the above information is accurate to the best of my ability.

Signature: _____

Patient #:_____ Date: _____