Global Laser Vision

PATIENT REGISTRATION FORM

Today's Date:	PCP:	Appointment Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	O Mr. O Mrs.	O Miss O Ms.	Marital status: O Single O Mar O Div O Sep O Wid

Email address:	Social Security no.:	Birth date:	Age:	Sex: O M O F

Cell phone no: ( )	Home phone no: ( )	Employer phone no: ( )	Extension

Rank your preferred method of being contacted (#1 = most preferred, # 5 = least preferred)

Home Phone Cell phone Work phone Mail e-mail Other:

Street address:	City:	State	Zip

Employer	Occupation

You were referred to our clinic by (Please check the boxes that apply and specify the names of the referring source):

☐ Family or Friend (Name?)	
☐ Advertising (Name?)	
☐ Dr. (Name?)	
☐ Other (Explain)	

INSURANCE INFORMATION(PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill:	Birth date:	Is this person a patient at Global Laser Vision? O Yes O No	Home phone no.: ( )

Address (if different): Street	City	State	Zip

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? O Yes O No

Do you have a Vision plan? ☐ VSP ☐ MESC ☐ Superior Vision ☐ Spectera ☐ Other

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment $

Patient's relationship to subscriber: O Self O Spouse O Child O Other (explain)

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: O Self O Spouse O Child O Other (explain)

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Global Laser Vision or insurance company to release any information required to process my claims.

Patient/Guardian signature	*Date*

Medical History Questionnaire
Global Laser Vision

Last	First	Middle	Date of Birth	Today's Date

Name of Primary Care Physician:	Last Eye Exam

HIPPA Notice and Acknowledgement (See document at the end of this form)

Acknowledgement: I hereby acknowledge that I have received and read the Notice of Privacy Practices (included with this form) ○ Yes ○ No

Chief Complaint- Eyes- Are you experiencing any of the following:

Blurred Vision	○ Yes	○ No	Floaters in Vision	○ Yes	○ No	Glare/Light Sensitivity	○ Yes	○ No
Burning	○ Yes	○ No	Flashes	○ Yes	○ No	Itching	○ Yes	○ No
Distortion/Halo	○ Yes	○ No	Eye Pain	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Double Vision	○ Yes	○ No	Excess Tearing	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Dryness	○ Yes	○ No	Discharge	○ Yes	○ No	Redness	○ Yes	○ No
Sandy/Gritty Feeling	○ Yes	○ No	Tired Eyes	○ Yes	○ No			

Has there been a change in your vision since your last examination? ○ Yes ○ No

If yes, please explain:

Ocular History: Do you currently or have you been diagnosed with the following: ☐ No to all

Cataracts	○ Yes	○ No	Keratoconus	○ Yes	○ No	Lazy Eyes	○ Yes	○ No
Amblyopia (Lazy eye)	○ Yes	○ No	Strabismus	○ Yes	○ No	Thyroid eye Disease	○ Yes	○ No
Droopy Eyelids	○ Yes	○ No	Styes or Chalazion	○ Yes	○ No	Retinal Disease	○ Yes	○ No
Glaucoma	○ Yes	○ No	Infection of Eye	○ Yes	○ No	Corneal Diseases	○ Yes	○ No
Eye Injury	○ Yes	○ No						

List all major eye surgeries you have had

Surgeries	Date	Surgeries	Date

If you wear contact lenses, please mark which type	☐ Soft	☐ Toric	☐ Hard /RGP	For how many years	
Frequency of contact lens use	○ Daily	○ often	○ Rarely	last time you wore contacts	
Do you wear glasses for distance	○ Yes	○ No		How old is your present pair	
Do you wear glasses for reading	○ Yes	○ No		How old is your reading pair	

Allergy and Medication History

Any Eye Allergies? ○ Yes ○ No

Do you rub your eyes frequently? ○ Yes ○ No

Do you have any allergies to any medications? ○ Yes ○ No

If yes, List below the medications or substances you have had reaction to and the type of the reaction you have had:

Medication or substances that has resulted in allergic response	Type of reaction

List all the medications you currently take (including eye medications and over the counter medications)

Review of Systems:

Do you currently or have you ever had any problems in the following areas:

(If the response to all of the questions listed in the review of systems below is no, you may use this checkmark in order to save time) ☐ **No to all**

Cardiovascular			**Gastrointestinal**			**Neurological**		
Heart trouble	O Yes	O No	Constipation	O Yes	O No	Lupus	O Yes	O No
High blood pressure	O Yes	O No	Diarrhea	O Yes	O No	Myasthenia gravis	O Yes	O No
Constitutional			Hepatitis	O Yes	O No	Headaches	O Yes	O No
Fever	O Yes	O No	**Genitourinary**			Migraines	O Yes	O No
Weight loss	O Yes	O No	Bladder	O Yes	O No	Seizures	O Yes	O No
Weight gain	O Yes	O No	Kidney	O Yes	O No	**Psychiatric**		
Cranial/Facial			**Hematologic/Lymphatic**			Anxiety or Depression	O Yes	O No
Chronic cough	O Yes	O No	Anemia	O Yes	O No	**Respiratory**		
Dry mouth	O Yes	O No	Bleeding disorders	O Yes	O No	Asthma	O Yes	O No
Ear infection	O Yes	O No	**Integumentary (Skin)**			Bronchitis	O Yes	O No
Sinus congestion	O Yes	O No	Keloid scarring	O Yes	O No	Emphysema	O Yes	O No
Herpes involving the eyes	O Yes	O No	**Musculoskeletal**			**Sexually transmitted Disease**		
Endocrine			Arthritis/rheumatoid	O Yes	O No	Syphilis	O Yes	O No
Diabetes	O Yes	O No	Joint pain	O Yes	O No	AIDS contact/HIV	O Yes	O No
Thyroid/Other glands	O Yes	O No	Muscle pain	O Yes	O No	**Other**	O Yes	O No
			Connective tissue dz	O Yes	O No			

Are you presently taking: ☐ **No to all**

Antibiotics	O Yes	O No	Heart Medications	O Yes	O No	Anti-Anxiety/Anti-Depressant	O Yes	O No
Aspirin (ASA)	O Yes	O No	Sleeping Medications	O Yes	O No	Contraceptive	O Yes	O No
Blood Pressure Med	O Yes	O No	Anti-Coagulants	O Yes	O No	Insulin	O Yes	O No
Pain Killers	O Yes	O No						

Female patients only:

Are you pregnant	O Yes	O No
Planning on getting pregnant in the next three months	O Yes	O No
Have been breast feeding for the past three months	O Yes	O No

Family History ☐ **No to all**

Disease/Condition			Relationship to you	Disease/Condition			Relationship to you
Blindness	O Yes	O No		Cataract	O Yes	O No	
Crossed Eyes	O Yes	O No		Diabetes	O Yes	O No	
Glaucoma	O Yes	O No		Heart Disease	O Yes	O No	
Keratoconus	O Yes	O No		High Blood Pressure	O Yes	O No	
Macular Degeneration	O Yes	O No		Kidney Disease	O Yes	O No	
Retinal Detachment	O Yes	O No		Lupus	O Yes	O No	
Retinal Disease	O Yes	O No		Thyroid Disease	O Yes	O No	
Arthritis	O Yes	O No		Other	O Yes	O No	
Cancer	O Yes	O No		Explain:			

Social History **This information is kept strictly confidential** ☐ **No to all**

Do you have visual difficulty when driving?	O Yes	O No	Explain:
Do you use tobacco?	O Yes	O No	Amount/How long:
Do you drink alcohol	O Yes	O No	How often:
Do you use illegal drugs?	O Yes	O No	If yes, type/amount/how long