

## Global Laser Vision PATIENT REGISTRATION FORM

Today's Date:		PCP:		Appointment Date:		
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="radio"/> Mr. <input type="radio"/> Miss <input type="radio"/> Mrs. <input type="radio"/> Ms.	Marital status: <input type="radio"/> Single <input type="radio"/> Mar <input type="radio"/> Div <input type="radio"/> Sep <input type="radio"/> Wid	
Email address:		Social Security no.:		Birth date:	Age:	Sex: <input type="radio"/> M <input type="radio"/> F
Cell phone no: (   )	Home phone no: (   )	Employer phone no: (   )		Extension		
Rank your preferred method of being contacted (#1 = most preferred, # 5 = least preferred)						
<input type="checkbox"/> Home Phone <input type="checkbox"/> Cell phone <input type="checkbox"/> Work phone <input type="checkbox"/> Mail <input type="checkbox"/> e-mail <input type="checkbox"/> 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):						
<input type="checkbox"/> Family or Friend (Name?)						
<input type="checkbox"/> Advertising (Name?)						
<input type="checkbox"/> Dr. (Name?)						
<input type="checkbox"/> Other (Explain)						
<b>INSURANCE INFORMATION(PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)</b>						
Person responsible for bill:		Birth date:	Is this person a patient at Global Laser Vision? <input type="radio"/> Yes <input type="radio"/> No		Home phone no.: (   )	
Address (if different): Street		City		State	Zip	
Occupation:	Employer:	Employer address:		Employer phone no.: (   )		
Is this patient covered by insurance? <input type="radio"/> Yes <input type="radio"/> No						
Do you have a Vision plan? <input type="checkbox"/> VSP <input type="checkbox"/> MESC <input type="checkbox"/> Superior Vision <input type="checkbox"/> Spectera <input type="checkbox"/> 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: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other (explain)						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other (explain)						
<b>IN CASE OF EMERGENCY</b>						
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
<b>HIPPA Notice and Acknowledgement (See document at the end of this form)</b>				
Acknowledgement: I hereby acknowledge that I have received and read the Notice of Privacy Practices (included with this form) <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No</span>				
<b>Chief Complaint- Eyes- Are you experiencing any of the following:</b>				
Blurred Vision	<input type="radio"/> Yes <input type="radio"/> No	Floaters in Vision	<input type="radio"/> Yes <input type="radio"/> No	Glare/Light Sensitivity <input type="radio"/> Yes <input type="radio"/> No
Burning	<input type="radio"/> Yes <input type="radio"/> No	Flashes	<input type="radio"/> Yes <input type="radio"/> No	Itching <input type="radio"/> Yes <input type="radio"/> No
Distortion/Halo	<input type="radio"/> Yes <input type="radio"/> No	Eye Pain	<input type="radio"/> Yes <input type="radio"/> No	Loss of Vision <input type="radio"/> Yes <input type="radio"/> No
Double Vision	<input type="radio"/> Yes <input type="radio"/> No	Excess Tearing	<input type="radio"/> Yes <input type="radio"/> No	Loss of Side Vision <input type="radio"/> Yes <input type="radio"/> No
Dryness	<input type="radio"/> Yes <input type="radio"/> No	Discharge	<input type="radio"/> Yes <input type="radio"/> No	Redness <input type="radio"/> Yes <input type="radio"/> No
Sandy/Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No	Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	
Has there been a change in your vision since your last examination? <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No</span>				
If yes, please explain: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>				
<b>Ocular History: Do you currently or have you been diagnosed with the following:</b> <span style="float: right;"><input type="checkbox"/> No to all</span>				
Cataracts	<input type="radio"/> Yes <input type="radio"/> No	Keratoconus	<input type="radio"/> Yes <input type="radio"/> No	Lazy Eyes <input type="radio"/> Yes <input type="radio"/> No
Amblyopia (Lazy eye)	<input type="radio"/> Yes <input type="radio"/> No	Strabismus	<input type="radio"/> Yes <input type="radio"/> No	Thyroid eye Disease <input type="radio"/> Yes <input type="radio"/> No
Droopy Eyelids	<input type="radio"/> Yes <input type="radio"/> No	Styes or Chalazion	<input type="radio"/> Yes <input type="radio"/> No	Retinal Disease <input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Infection of Eye	<input type="radio"/> Yes <input type="radio"/> No	Corneal Diseases <input type="radio"/> Yes <input type="radio"/> No
Eye Injury	<input type="radio"/> Yes <input type="radio"/> No			
List all major eye surgeries you have had				
Surgeries	Date	Surgeries	Date	
If you wear contact lenses, please mark which type		<input type="checkbox"/> Soft	<input type="checkbox"/> Toric	<input type="checkbox"/> Hard /RGP
Frequency of contact lens use		<input type="radio"/> Daily	<input type="radio"/> often	<input type="radio"/> Rarely
Do you wear glasses for distance		<input type="radio"/> Yes	<input type="radio"/> No	For how many years
Do you wear glasses for reading		<input type="radio"/> Yes	<input type="radio"/> No	last time you wore contacts
				How old is your present pair
				How old is your reading pair
<b>Allergy and Medication History</b>				
Any Eye Allergies?				<input type="radio"/> Yes <input type="radio"/> No
Do you rub your eyes frequently?				<input type="radio"/> Yes <input type="radio"/> No
Do you have any allergies to any medications?				<input type="radio"/> Yes <input type="radio"/> 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)				

<b>Review of Systems:</b>			
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)			<input type="checkbox"/> No to all
<b>Cardiovascular</b>		<b>Gastrointestinal</b>	
Heart trouble	<input type="radio"/> Yes <input type="radio"/> No	Constipation	<input type="radio"/> Yes <input type="radio"/> No
High blood pressure	<input type="radio"/> Yes <input type="radio"/> No	Diarrhea	<input type="radio"/> Yes <input type="radio"/> No
<b>Constitutional</b>		<b>Neurological</b>	
Fever	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input type="radio"/> No
Weight loss	<input type="radio"/> Yes <input type="radio"/> No	<b>Genitourinary</b>	
Weight gain	<input type="radio"/> Yes <input type="radio"/> No	Bladder	<input type="radio"/> Yes <input type="radio"/> No
<b>Cranial/Facial</b>		Kidney	<input type="radio"/> Yes <input type="radio"/> No
Chronic cough	<input type="radio"/> Yes <input type="radio"/> No	<b>Hematologic/Lymphatic</b>	
Dry mouth	<input type="radio"/> Yes <input type="radio"/> No	Anemia	<input type="radio"/> Yes <input type="radio"/> No
Ear infection	<input type="radio"/> Yes <input type="radio"/> No	Bleeding disorders	<input type="radio"/> Yes <input type="radio"/> No
Sinus congestion	<input type="radio"/> Yes <input type="radio"/> No	<b>Integumentary (Skin)</b>	
Herpes involving the eyes	<input type="radio"/> Yes <input type="radio"/> No	Keloid scarring	<input type="radio"/> Yes <input type="radio"/> No
<b>Endocrine</b>		<b>Musculoskeletal</b>	
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Arthritis/rheumatoid	<input type="radio"/> Yes <input type="radio"/> No
Thyroid/Other glands	<input type="radio"/> Yes <input type="radio"/> No	Joint pain	<input type="radio"/> Yes <input type="radio"/> No
		Muscle pain	<input type="radio"/> Yes <input type="radio"/> No
		Connective tissue dz	<input type="radio"/> Yes <input type="radio"/> No
<b>Are you presently taking:</b>			<input type="checkbox"/> No to all
Antibiotics	<input type="radio"/> Yes <input type="radio"/> No	Heart Medications	<input type="radio"/> Yes <input type="radio"/> No
Aspirin (ASA)	<input type="radio"/> Yes <input type="radio"/> No	Sleeping Medications	<input type="radio"/> Yes <input type="radio"/> No
Blood Pressure Med	<input type="radio"/> Yes <input type="radio"/> No	Anti-Coagulants	<input type="radio"/> Yes <input type="radio"/> No
Pain Killers	<input type="radio"/> Yes <input type="radio"/> No		
<b>Female patients only:</b>			
Are you pregnant			<input type="radio"/> Yes <input type="radio"/> No
Planning on getting pregnant in the next three months			<input type="radio"/> Yes <input type="radio"/> No
Have been breast feeding for the past three months			<input type="radio"/> Yes <input type="radio"/> No
<b>Family History</b>			<input type="checkbox"/> No to all
Disease/Condition	Relationship to you	Disease/Condition	Relationship to you
Blindness	<input type="radio"/> Yes <input type="radio"/> No	Cataract	<input type="radio"/> Yes <input type="radio"/> No
Crossed Eyes	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Heart Disease	<input type="radio"/> Yes <input type="radio"/> No
Keratoconus	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No	Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No	Lupus	<input type="radio"/> Yes <input type="radio"/> No
Retinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Other	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Explain:	
<b>Social History</b> **This information is kept strictly confidential**			<input type="checkbox"/> No to all
Do you have visual difficulty when driving?	<input type="radio"/> Yes <input type="radio"/> No	Explain:	
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No	Amount/How long:	
Do you drink alcohol	<input type="radio"/> Yes <input type="radio"/> No	How often:	
Do you use illegal drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes, type/amount/how long	