La Grande Family Eye Care Registration Form

(Please Print)

Patient Information				
Last name: First: Middle:		Date of Birth: / /	Sex: ☐ M ☐ F	Marital Status: ☐ S ☐ M ☐ Other
Street Address/P.O. Box: City: State: Zip:				Home phone: ( )
Last 4 of Social Security #: XXX - XX -	Occupation:	Employer:		Work phone: ( )
Why did you choose La Grande Family Eye Care? ☐ Existing patient ☐ Referred by: ☐ Phone book ☐ Internet ☐ Insurance Plan ☐ Other (explain):				

Insurance Information		
Primary Insurance:	Insured's name (if different):	Date of Birth:
Address (if different):	ID/Membership #:	
Secondary Insurance:	Insured's name (if different):	Date of Birth:
Address (if different):	ID/Membership #:	

*Any payment in excess to what insurance is expected to cover, for services and/or materials, is due at the time of service

Health Information		
Reason for today's visit:		Date and location of last eye exam:
Are you interested in…? ☐ glasses ☐ contacts ☐ LASIK ☐ Other (explain):		
Primary care physician:	Last physical exam:	Pharmacy:
Current Medications:	List any allergies you have, including medication allergies:	
Do you use any of the following: ☐ tobacco ☐ alcohol ☐ recreational drugs		

Review of Systems: Do you have any problems with…

Eyes	**Y**	**N**	**Constitutional**	**Y**	**N**	**Genitourinary**	**Y**	**N**
Double Vision	☐	☐	Fever	☐	☐	Kidneys	☐	☐
Cataracts	☐	☐	Weight Loss	☐	☐	Bladder	☐	☐
Lazy Eye	☐	☐	**Cardiovascular**			**Hematologic/Lymphatic**		
Flashes/Floaters	☐	☐	Blood Pressure	☐	☐	Anemia	☐	☐
Dryness	☐	☐	**Ears, Nose, Mouth, Throat**			Bleeding Disorders	☐	☐
Itching	☐	☐	Sinus	☐	☐	**Integumentary**		
Eye Pain	☐	☐	Cough	☐	☐	Skin	☐	☐
Glare	☐	☐	Hearing Loss	☐	☐	**Musculoskeletal**		
Halos	☐	☐	**Endocrine**			Arthritis	☐	☐
Eye Surgery	☐	☐	Diabetes	☐	☐	Muscle/Joint Pain	☐	☐
Eye Injury	☐	☐	Thyroid	☐	☐	**Neurological**		
Retinal Detachment	☐	☐	**Gastrointestinal**			Headaches	☐	☐
Glaucoma	☐	☐	Ulcers	☐	☐	Migraines	☐	☐
Macular Degeneration	☐	☐	Diarrhea/Constipation	☐	☐	**Psychiatric**		
Family History	**Y**	**N**	**Respiratory**			Depression	☐	☐
Glaucoma	☐	☐	Asthma	☐	☐	Anxiety	☐	☐
Macular Degeneration	☐	☐	Emphysema	☐	☐			

I affirm that the above information is correct. I understand that it is my responsibility to check my current insurance coverage. I authorize the use of my protected health information in accordance with the guidelines of the Notice of Privacy Practices. I also authorize my insurance carrier to pay benefits directly to La Grande Family Eye Care.

Patient/Guardian Signature ____ Date ______________