GWINNETT EYE CLINIC

REGISTRATION INFORMATION

Date: ____________________ **(PLEASE PRINT)** Home Phone: (_______) ____________________

Cell Phone: (_______) ____________________

Email: ____________________

Patient: ____

Last Name *First Name* *Initial*

Responsible Party (if minor): ____________________

Street Address: ____________________

City: ____________________ State: ____________ Zip: ____________

Sex: ☐ M ☐ F Age: ______ Birth Date: ____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By : ____________________

Business Address : ____________________

Occupation : ____________________ Business Phone: (_______) ____________

Spouse (or responsible party) Employed By : ____________________

Business Address : ____________________

Occupation : ____________________ Business Phone: (_______) ____________

Purpose of Visit: ____________________

Who is responsible for this account? ____________________ Relationship to Patient: ____________

Social Security # ____________________ Spouse's Social Security # ____________________

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer: ____________________

Member ID ____________________ Group # ____________________

Do you have Vision Insurance? ☐ No ☐ Yes If yes,

Name of Insurer: ____________________

Member ID ____________________ Group # ____________________

Name of Secondary Insurer (if any): ____________________

Member ID ____________________ Group # ____________________

☐ Medicare ☐ Medicaid Claim ID # ____________________

PAYMENT IN FULL IS DUE AT TIME OF SERVICE — $25 Return Check Fee

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ____________________ hereby authorize ____________________

(Name of Insured) *(Name of Insurance Company)*

to pay and hereby assign directly to **Gwinnett Eye Clinic** all benefits, if any, otherwise payable

(Provider's Name)

to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to **Gwinnett Eye Clinic**

(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

AUTHORIZED SIGNATURE OF SUBSCRIBER: ____________________ Date: ____________

Rev. 01/08

MEDICAL HISTORY

Name______________________________ Date_____/_____/_____

Address______________________________ Phone______________

City______________ State______ Zip__________ Work Phone______________

Guardian (if applicable)______________________________ Occupation______________

Birthdate _____/_____/_____ Email______________________ Last Eye Exam _____/_____/_____

Do you have vision insurance? ☐ No ☐ Yes If yes, insurance carrier ______________________

Do you have health insurance? ☐ No ☐ Yes If yes, insurance carrier ______________________

Do you have medicare? ☐ No ☐ Yes

Medical History

Do you have any allergies to medication? ☐ No ☐ Yes If yes, explain ______________________

List medications you take (including oral contaceptives, aspirin, over-the-counter medications and home remedies)

List all major injuries, surgeries and/or hospitalizations you have had ______________________

List any of the following that you have had - crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury______________________

Are you pregnant and/or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?__________

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?__________

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ No ☐ Yes

Eyes - Conditions

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	
Loss of Vision	☐	☐	
Blurred Vision	☐	☐	
Distorted Vision/Halos	☐	☐	
Loss of Side Vision	☐	☐	
Double Vision	☐	☐	
Dryness	☐	☐	
Mucous Discharge	☐	☐	
Redness	☐	☐	
Sandy or Gritty Feeling	☐	☐	
Itching	☐	☐	

Eyes - Conditions (continued)

	No	Yes	
Burning	❒	❒	
Foreign Body Sensation	❒	❒	
Excess Tearing/Watering	❒	❒	
Glare Light Sensativity	❒	❒	
Eye Pain or Soreness	❒	❒	
Chronic Infection of Eye or Lid	❒	❒	
Sties or Chalazion	❒	❒	
Flashes or Floaters in Vision	❒	❒	
Tired Eyes	❒	❒	

Patient Family History

			Self	Relationship (Father, Mother, etc.)
Blindness	❒	❒		
Cataract	❒	❒		
Crossed Eyes	❒	❒		
Glaucoma	❒	❒		
Macular Degeneration	❒	❒		
Retinal Detachment/Disease	❒	❒		
Arthritis	❒	❒		
Cancer	❒	❒		
Diabetes	❒	❒		
Heart Disease	❒	❒		
High Blood Pressure	❒	❒		
Kidney Disease	❒	❒		
Lupus	❒	❒		
Throid Disease	❒	❒		
Other	❒	❒		

Social History - This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ❒ No ❒ Yes If yes, do you have visual difficulty when driving? ❒ No ❒ Yes

If yes, please describe: ______________________

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Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long ______________________

Do you drink alcohol? ❒ No ❒ Yes If yes, type/amount/how long ______________________

Do you use illegal drugs? ❒ No ❒ Yes If yes, type/amount/how long ______________________

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

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Review of Systems

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

	No	Yes
Constitutional		
Fever, Weight Loss/Gain	☐	☐
Integumentary		
Skin	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐
Ear, Nose, Mouth, Throat		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐

	No	Yes
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Chronic Diarrhea	☐	☐
Chronic Constipation	☐	☐
Genitourinary		
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric	☐	☐

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

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Doctor's Signature______________________________ Date_______/_______/_______