Blair Eye Associates

REGISTRATION FORM

Welcome to Blair Eye Associates. We appreciate the opportunity to care for your health and take care of your vision necessities. Please fill out this form to the best your ability. We will do everything necessary to take the best care of your health and vision as well as protect your health information. Thanks again for your trust in our services.

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Rev.	Marital status (Check applicable) ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow		
Is this your legal name? ❑ Yes ❑ No Alternate Name(s):	Social Security #:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Address #2	City:	State:	ZIP Code: Home Phone: ( )
Cell Phone: ( )	May we contact you on your cell phone? ❑ Yes ❑ No	**Preferred Phone for Contact: ❑ Home ❑ Work ❑ Cell**		
Email:	May we contact you at this email? (Appointment reminders, materials arrival, education purposes, etc…) ❑ Yes ❑ No			

Language: ❑ English ❑ Spanish ❑ German ❑ French ❑ Japanese ❑ Chinese ❑ Other ❑ Declined

Race: ❑ White ❑ Hispanic or Latino ❑ American Indian or Alaska Native ❑ African American ❑ Asian ❑ Native Hawaiian or Pacific Islander ❑ Other ❑ Declined

Ethnicity: ❑ Caucasian ❑ Hispanic or Latino ❑ African-American ❑ Asian ❑ Not Hispanic/Latino ❑ Other ❑ Declined

EMPLOYMENT INFORMATION

Occupation:	Employer and Address:	Work Phone No: ( )	May we contact you at ❑ Yes ❑ No

IN CASE OF EMERGENCY

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

Chose clinic because/Referred to clinic by ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Yellow Pages

(please check one box): ❑ Family ❑ Friend ❑ Close to home/work ❑ Other

Other family members seen here:

OCULAR HISTORY

How long since your last eye exam? __ Yr(s)	Do you wear glasses? ❑ Yes ❑ No (Never) ❑ Lost or Broken (Not wearable)			
Do you wear Contact Lenses? ❑ Yes ❑ No	If Yes – What Brand?	CL Solution _____		

Past Ocular History

❑ Amblyopia (Lazy Eye) ❑ Aphakia (Surgery to remove a lens without replacement)	❑ Cataracts ❑ Diabetic Retinopathy ❑ Dry Eyes	❑ Glaucoma ❑ Graves Disease ❑ Herpes Simplex ❑ Herpes Zoster (Shingles)	❑ Histoplasmosis ❑ Iritis ❑ Keratoconus	❑ Macular Degeneration ❑ Optic Neuritis ❑ Retinal Detachment

Have you had any injuries to your eyes? ❑ Yes ❑ No If yes, please list and explain:

Have you had any type of eye surgery?	❑ LASIK/PRK	❑ Cataract	❑ Retinal Detachment	❑ Blepharoplasty (Eyelid)	❑ Glaucoma
	❑ RK	❑ Strabismus	❑ Corneal Transplant	❑ Removal of Foreign Material (metal, etc…)	❑ Other _____

Date of Surgery(s) (if recalled):

PERSONAL (YOUR) MEDICAL HISTORY

Vitals and Measurements		**Constitutional** *(General Health)*	**Ear Nose Throat**	**Neurological** *(Brain/Nervous System)*
What is your height? ft	in	❑ **Negative/None** ❑ Fatigue ❑ Cancer ❑ Fever ❑ Excessive Weight Gain/Loss ❑ Excessive Thirst ❑ Loss of Appetite ❑ Other	❑ **Negative/None** ❑ Hearing Loss ❑ Sinusitis ❑ Dry Mouth ❑ Laryngitis ❑ Other	❑ **Negative/None** ❑ Multiple Sclerosis ❑ Epilepsy ❑ Cerebral Palsy ❑ Tumor ❑ Stroke/CVA ❑ Migraine ❑ Other
What is your weight? lbs				
Blood Sugar mg/dl				
A1c (3 Month Average) % (i.e. 6.2)				
Blood Pressure /				
Dominant Hand ❑ Right ❑ Left				

Psychological *(Mood & Behavior)*	**Cardiovascular** *(Heart & Vessels)*	**Respiratory** *(Breathing)*	**Gastrointestinal** *(Stomach & Digestion)*	**Genitourinary** *(Urinary/Bowels)*
❑ **Negative/None** ❑ Depression ❑ Attention Deficit ❑ Anxiety Disorder ❑ Bipolar Disorder ❑ Other	❑ **Negative/None** ❑ High Blood Pressure ❑ Stroke/CVA ❑ Heart Disease ❑ Vascular Disease ❑ Congestive Heart Failure ❑ Other	❑ **Negative/None** ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Chronic Obstruction ❑ Sleep Apnea ❑ Other	❑ **Negative/None** ❑ Crohn's ❑ Colitis ❑ Ulcer ❑ Acid Reflux ❑ Celiac Disease ❑ General Indigestion ❑ Other	❑ **Negative/None** ❑ Kidney Disease ❑ Prostate Disease/Cancer ❑ STD ❑ Benign Prostatic Hypertrophy ❑ Pregnant ❑ Nursing ❑ Other

Musculoskeletal *(Bones/Joints/Ligaments)*	**Integumentary** *(Skin)*	**Endocrinology** *(Hormones & Chemicals)*	**Hematologic/Lymphatic** *(Blood & Fluids)*	**Allergy/Immunology** *(Auto-Immune)*
❑ **Negative/None** ❑ Arthritis ❑ Fibromyalgia ❑ Muscular Dystrophy ❑ Ankylosing Spondylitis ❑ Osteoporosis ❑ Gout ❑ Other	❑ **Negative/None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Herpes Simplex/Cold Sores ❑ Herpes Zoster/Shingles ❑ Other	❑**Negative/None** ❑Type 1 Diabetes Mellitus ❑Type 2 Diabetes Mellitus ❑Thyroid Dysfunction ❑Hormonal Dysfunction ❑Other	❑**Negative/None** ❑ Anemia ❑ Large-Volume Blood Loss ❑ Ulcer ❑ High Cholesterol ❑ Other	❑ **Negative/None** ❑ Drug Allergies ❑ Environmental Allergies ❑ Rheumatoid Arthritis ❑ Lupus ❑ Sjogren's Syndrome ❑ Other

Who is your Medical Doctor/Specialist?	
Have you had any major surgeries? (i.e. hip, gallbladder, cancer removal, open heart, etc…)?	

MEDICATIONS/VITAMINS/SUPPLEMENTS/ OVER THE COUNTER

Name of Medication	Medical Condition	Dosage	Frequency

❑ **See Attached Sheet of Medication brought by Patient**

ALLERGIES

Medication Allergies ❑ Yes ❑ No		**Environmental/Other Allergies** ❑ Yes ❑ No	
Allergy	Reaction	Allergy	Reaction

Do you have an allergy to Latex? ❑ Yes ❑ No

SOCIAL HISTORY

Do you drink or use alcohol?	❑ Yes	❑ No	If yes, please specify: ____drinks per day/week/month
Do you smoke or use chewing tobacco?	❑ Yes	❑ No	If yes, please specify: ____cigarettes/packs per day | ____dips/cans per day
Do you currently or have you used recreational drugs in the past?	❑ Yes	❑ No	If yes, please specify:

FAMILY (IMMEDIATE) MEDICAL HISTORY

****Family applies only to immediate family – i.e. Parents, siblings, grandparents and great-grandparents – Aunts and Uncles can apply if you would like.****

Past Family Medical History	**Affected Family Members**
❑ **Negative/None**	
❑ High Blood Pressure	
❑ Diabetes Mellitus	
❑ Cancer	
❑ Thyroid Dysfunction	
❑ Stroke/CVA	
❑ Multiple Sclerosis	
❑ Other	

Past Family Ocular History	**Affected Family Members**
❑ **Negative/None**	
❑ Cataracts	
❑ Diabetic Retinopathy	
❑ Glaucoma	
❑ Keratoconus	
❑ Macular Degeneration	
❑ Retinal Detachment	
❑ Other	

SIGNATURE AND ATTESTATION

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits be paid directly to the Dr. Ryan G. Palmer and Blair Eye Associates. I understand that I am financially responsible for any balance. I also authorize Blair Eye Associates, L.L.C. or insurance company to release any information necessary or required to process my claims.

_____ _____

Patient/Guardian signature ***Date***

Blair Eye Associates

We need some more information regarding your insurance/vision plan/other coverage. Please fill out the appropriate parts of the form below so that we may accurately file your insurance for you in a timely manner. Thank you for your assistance.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

A

Please indicate primary insurance

❑ Medicare ❑ Medicaid ❑ Blue Cross and Blue Shield ❑ United Healthcare ❑ Coventry
❑ Aetna ❑ Other (Please Specify) _____

Policy Holder Name:	Policy Holder S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

Patient's relationship to Plan Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other

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

B

Person responsible for payment:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

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

VISION PLAN INFORMATION

Do you subscribe to a Vision Plan or Discount Vision Plan? ❑ Yes If so please specify which Plan below: ❑ No

❑ VSP ❑ EyeMed ❑ Other (Please Specify): _____

Primary Plan Holder's name:	Primary Plan Holder's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to Plan Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other