STAFF INITIALS _____

SIGHT TRUST
EYE INSTITUTE

PATIENT REGISTRATION FORM

DATE _____

NAME: FIRST _____ MI _____ LAST _____ AGE _____ SEX: M/F

PREFERRED NAME _____ HOME PHONE_____

BIRTH DATE _____/____/_____ CELL PHONE _____

ADDRESS _____ APT# _____

CITY _____ STATE _____ ZIP _____ SSN _____ - ___ - _____

E-MAIL ADDRESS _____

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS: SINGLE MARRIED PARTNER WIDOWED DIVORCED

PHARMACY _____ PHONE NUMBER_____

Insurance Information (Disregard for LASIK/PHAKIC Patients)

PRIMARY INSURANCE _____ PHONE NUMBER _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP#_____

DATE OF BIRTH _____ SSN _____ - ___ - _____

SECONDARY INSURANCE _____ PHONE NUMBER _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

ID# _____ GROUP#_____

DATE OF BIRTH _____ SSN _____ - ___ - _____

Emergency Contact

FULL NAME _____ RELATIONSHIP TO PATIENT _____

PHONE NUMBER _____ ADDRESS _____

HIPAA Contact List

SightTrust and its associates and staff have my permission to speak to the following family members/friends in reference to my medical care:

FULL NAME _____ RELATIONSHIP TO PATIENT _____

FULL NAME _____ RELATIONSHIP TO PATIENT _____

FULL NAME _____ RELATIONSHIP TO PATIENT _____

WHOM MAY WE THANK FOR THIS REFERRAL? _____

SIGHT TRUST
EYE INSTITUTE

HEALTH HISTORY

PATIENT NAME:_____ DATE: _____

Past Medical History

Please check off if you have been diagnosed with any of the following:

- ☐ Anxiety/ Depression
- ☐ Migraines/Headache
- ☐ Diabetes (Insulin use? _____)
- ☐ Carotid Artery Disease
- ☐ Heart Disease: Pacemaker/ Defibrillator/ Arrhythmia/ Stents
- ☐ Hypertension
- ☐ Heart Attack/ MI/ TIA
- ☐ Neurological Disease
- ☐ Seizures / Stroke
- ☐ COPD / Sleep Apnea/ CPAP
- ☐ Shortness of Breath
- ☐ Asthma (Inhaler use? _____)
- ☐ Lung Disease
- ☐ Prostate Disease (meds for prostate or hair growth? _____)
- ☐ Cancer
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Autoimmune Disorder
- ☐ Currently Pregnant/ Nursing
- ☐ Other: _____

Past Ocular History

Please check off if you have been diagnosed with any of the following:

- ☐ Amblyopia
- ☐ Cataract
- ☐ Dry Eye(s)
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Corneal Disease: Keratoconus
- ☐ Crossed Eyes
- ☐ Injury/ Abrasion
- ☐ Iritis
- ☐ Other Eye Disorders: _____

Past Ocular Surgeries

- ☐ Cataract
- ☐ LASIK/ PRK/ RK
- ☐ Plastic Surgery (Blepharoplasty)
- ☐ Glaucoma Surgery
- ☐ Retina Surgery
- ☐ Other Ocular Surgery: _____

Please list all Allergies/reactions

No Known Allergies/ Latex Allergy/ Iodine Allergy/ Sulfa Allergy

Allergies: _____

Please list all current medications: *Prescribed and over the counter*

_____

_____

Please list all previous surgeries/procedures (including year):

_____

_____

List anyone in your immediate family who has the following:

(Mother, Father, Sister, Brother)

- ☐ Macular Degeneration
- ☐ Corneal Disease
- ☐ Glaucoma
- ☐ Other Ocular Disease:_____

Social History:

- ☐ Smoke: No / Yes _____ packs per day/week/month/socially
- ☐ Alcohol: No / Yes _____ drinks per day/week/month/socially