



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

Insurance Information

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? _____

HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

Past Medical History

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety/ Depression | <input type="checkbox"/> Heart Attack/ MI/ TIA | <input type="checkbox"/> Prostate Disease (meds for prostate or hair growth? _____) |
| <input type="checkbox"/> Migraines/Headache | <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes (Insulin use? _____) | <input type="checkbox"/> Seizures / Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> COPD / Sleep Apnea/ CPAP | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Heart Disease: Pacemaker/ Defibrillator/ Arrhythmia/ Stents | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma (Inhaler use? _____) | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Lung Disease | |

Past Ocular History

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Iritis | <input type="checkbox"/> Plastic Surgery (Blepharoplasty) |
| <input type="checkbox"/> Dry Eye(s) | <input type="checkbox"/> Other Eye Disorders: _____ | <input type="checkbox"/> Glaucoma Surgery |
| <input type="checkbox"/> Glaucoma | | <input type="checkbox"/> Retina Surgery |
| <input type="checkbox"/> Macular Degeneration | | <input type="checkbox"/> Other Ocular Surgery: _____ |
| <input type="checkbox"/> Retinal Disease | | |
| <input type="checkbox"/> Corneal Disease | | |
| <input type="checkbox"/> Crossed Eyes | | |
| <input type="checkbox"/> Injury/ Abrasion | | |

Past Ocular Surgeries

- Cataract
 LASIK/ PRK/ RK

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)

- | | |
|---|--|
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Other Ocular Disease: _____ |
| <input type="checkbox"/> Corneal Disease | |
| <input type="checkbox"/> Glaucoma | |

Social History:

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