SOUTHWEST FLORIDA EYE CARE

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name: Mr. Mrs. Ms. Dr. _____

Date of Birth: _____ **SSN:** _____ ☐ Male ☐ Female

Address: _____

Home Number: _____ **Cell Phone:** _____

Email Address: _____ **Marital Status:** _____

Race: ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Language: ☐ English ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Other: _____

Florida Resident: ☐ Full Time ☐ Part Time If Part Time, please complete information below.

From: _____ To: _____ Secondary Home Phone: _____

Secondary Address: _____

Northern Physician: _____ Phone: _____ Fax: _____

Responsible Party Information (If different from above):

Name: _____ Date of Birth: _____

Primary Insurance: _____ **Policy #:** _____

Secondary Insurance: _____ **Policy #:** _____

Are you or your spouse employed full time or part time? ☐ Yes ☐ No

If so, do you have health insurance through your employer? ☐ Yes ☐ No

Are you enrolled in an HMO? ☐ Yes ☐ No

Do you need authorization from your Primary Physician to see a specialist? ☐ Yes ☐ No

Have you been in a skilled nursing a facility and/or hospice care in the past 6 months? ☐ Yes ☐ No

If yes, what is the name of the Facility? _____

How did you hear about Southwest Florida Eye Care? ☐ Billboard/Building Signage ☐ Doctor ☐ Event

☐ Family/Friend ☐ Google/Online Search ☐ Other: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

SOUTHWEST FLORIDA EYE CARE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Primary Eye Physician: _____ Phone: _____

Address: _____ Fax: _____

Height: _____ **Weight:** _____

Ocular History:

☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	LASIK / Epi-LASEK
☐ Yes	☐ No	Cornea Transplant	☐ Yes	☐ No	Macular Degeneration
☐ Yes	☐ No	Diabetic Retinopathy	☐ Yes	☐ No	Punctal Plugs
☐ Yes	☐ No	Dry Eye Syndrome	☐ Yes	☐ No	Retinal Detachment
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	YAG Laser

☐ Other: _____

What is the reason for your visit today?

☐ Blurred Vision	RT	LT	☐ Dry Eyes	RT	LT	☐ Itching	RT	LT
☐ Decreased Vision	RT	LT	☐ Flashes	RT	LT	☐ Pain	RT	LT
☐ Discharge	RT	LT	☐ Floaters	RT	LT	☐ Red Eye	RT	LT
☐ Double Vision	RT	LT	☐ Headache	RT	LT	☐ Tearing	RT	LT

☐ Other: _____

Immunization / Vaccination:

☐ Yes ☐ No Influenza Date/s: _____

☐ Yes ☐ No Pneumococcal Date: _____

Surgical History:

☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No	Hemorrhoidectomy
☐ Yes	☐ No	Carotid Endarterectomy	☐ Yes	☐ No	Hysterectomy
☐ Yes	☐ No	Gallbladder	☐ Yes	☐ No	Mastectomy
☐ Yes	☐ No	Heart Bypass	☐ Yes	☐ No	Prostate
☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Skin Cancer Removal

☐ Other: _____

Allergies:

☐ Yes ☐ No Latex Please describe: _____

☐ Yes ☐ No Anesthesia Please describe: _____

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Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History:

☐ Yes ☐ No	Cataracts	☐ Mother	☐ Father	☐ Other: _____
☐ Yes ☐ No	Diabetes	☐ Mother	☐ Father	☐ Other: _____
☐ Yes ☐ No	Glaucoma	☐ Mother	☐ Father	☐ Other: _____
☐ Yes ☐ No	Macular Degeneration	☐ Mother	☐ Father	☐ Other: _____
☐ Yes ☐ No	Retinal Detachment	☐ Mother	☐ Father	☐ Other: _____
☐ Other: _____		☐ Mother	☐ Father	☐ Other: _____

Social History:

Occupation: _____ ☐ Retired ☐ Disabled ☐ Not Working

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Walking ☐ Other: _____

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

Past / Present Medical History:

☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No	Hearing Loss
☐ Yes ☐ No	Alzheimer's	☐ Yes ☐ No	Heart Attack: Year _____
☐ Yes ☐ No	Anxiety	☐ Yes ☐ No	High Blood Pressure/Hypertension
☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Irregular Heartbeat
☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Kidney Disease
☐ Yes ☐ No	Autoimmune Disease	☐ Yes ☐ No	Kidney Failure
☐ Yes ☐ No	Bleeding	☐ Yes ☐ No	Kidney Stones
☐ Yes ☐ No	Bruises	☐ Yes ☐ No	Migraine
☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Nausea
☐ Yes ☐ No	Cardiovascular Disease	☐ Yes ☐ No	Parkinson
☐ Yes ☐ No	Cholesterol	☐ Yes ☐ No	Psoriasis
☐ Yes ☐ No	COPD	☐ Yes ☐ No	Seasonal Allergies
☐ Yes ☐ No	Dementia	☐ Yes ☐ No	Sinus Problems
☐ Yes ☐ No	Depression	☐ Yes ☐ No	Skin Rashes
☐ Yes ☐ No	Diabetes: Type 1 or Type 2	☐ Yes ☐ No	Stroke: Year _____
☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Stomach Ulcers
☐ Yes ☐ No	Hearing Aides	☐ Yes ☐ No	Thyroid Disease

☐ Other: _____