ocean | eye

Patient Registration Form

Patient's Name: _____ SSN: _____ DOB: _____ Gender: _____

Mailing Address: _____ Phone: _____

City:_____ State: _____ Zip:_____ Cell: _____

Occupation: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Guarantor (if patient is a minor): _____ Relationship: _____

Guarantor's Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Location: _____

Primary Insurance: _____ Phone: _____

Policy ID #:_____ Group #: _____

Policy Holder:_____ DOB: _____

Effective Date: _____ Copay: _____

Deductible: _____ Coinsurance: _____

Notes: _____ Out of Pocket: _____

Representative: _____ Date: _____

I consent to medical examination, treatment, and diagnostic studies advised by the physician. I authorize and assign my insurance benefits be paid directly to the practice. Ocean Eye will offer what they feel, in their medical opinion, is medically necessary for my healthcare. I understand some services advised by my doctor may or may not be covered by insurance. I understand that I am financially responsible for any outstanding balance and will promptly pay this in full within 30 days of receiving a bill. I understand that accounts 120 days past due will be transferred to a third party collections agency and that I will be responsible for any and all fees associated with this transfer. I also authorize Ocean Eye and/or my insurance company to release any information required to process my claims.

_____ _____

Patient or Guarantor Date

PAST MEDICAL HISTORY

PATIENT NAME: _____ DOB: _____ TODAY'S DATE: _____

Eye Problems

☐ Cataracts ☐ Macular Degeneration
☐ Glaucoma ☐ Dry Eyes
☐ Other

_____
_____
_____

☐ None

Eye Medications

Medication name	*Dose*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ None

Other Medical Problems

☐ Hypertension ☐ Diabetes
☐ Heart Disease ☐ Cancer
☐ Asthma ☐ Rheumatoid Arthritis
☐ Other (Include Any Surgical Procedures)

_____
_____
_____
_____
_____

☐ None

Medications (Including Alternative/Herbal)

Medication Name	*Dose*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ None

Family Medical History

	Family Member(s):
☐ Glaucoma	_____
☐ Macular Degeneration	_____
☐ Hypertension	_____
☐ Diabetes	_____
☐ Other	
_____	_____
_____	_____
_____	_____
_____	_____

☐ None

Social History

Smoking ☐ No ☐ Yes

Alcohol ☐ No ☐ Yes

Allergies	***Reaction?***
_____	_____
_____	_____
_____	_____

☐ No Known Drug Allergy

REVIEW OF SYSTEMS

PATIENT NAME: _____ DOB: _____ TODAY'S DATE:_____

FOR THE FOLLOWING CONDITIONS, PLEASE CHECK THE SYMPTOMS YOU **CURRENTLY** HAVE:

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Irregular Heartbeat
- ☐ Other _____

CONSTITUTIONAL

- ☐ Chills
- ☐ Fever
- ☐ Weight Loss
- ☐ Other _____

EYES

- ☐ Eye Pain
- ☐ Vision Change
- ☐ Floaters
- ☐ Other_____

ENDOCRINE

- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Hair Loss
- ☐ Other _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Changes in Bowel
- ☐ Other _____

GENITOURINARY

- ☐ Burning on Urination
- ☐ Urinary Retention
- ☐ Blood in Urine
- ☐ Other _____

EAR, NOSE, THROAT

- ☐ Hearing Loss
- ☐ Nasal or Sinus Congestion
- ☐ Dry Mouth
- ☐ Other _____

SKIN

- ☐ Rash
- ☐ Itching
- ☐ Skin Sores
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Muscle Aches
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Other_____

NEUROLOGICAL

- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Frequent Headaches
- ☐ Other _____

PULMONARY

- ☐ Wheezing
- ☐ Coughing
- ☐ Difficulty Breathing
- ☐ Other _____

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty Sleeping
- ☐ Other _____

Updated 4/15/2014

☐ **NO CURRENT SYMPTOMS**