WASHINGTON
EYE
PHYSICIANS & SURGEONS

PATIENT REGISTRATION FORM

B S M R W A G KS MAC Z GR SO ZA L

Please tell us about yourself so we can help you make the best decisions about your care.

Date: _____ Social Security #:_____ E-mail:_____

Name: _____
MR / MRS / MS / MISS LAST FIRST M.I.

Address:_____
STREET APT. # CITY STATE ZIP CODE

Sex: _____ Birthdate:_____ Spouse/Partner:_____

Home Ph.(____)_____ Work Ph.(____)_____ Cell Ph.(____)_____

Occupation: _____ Employer:_____

Emergency Contact: _____

Person to be billed:_____ (____)_____
NAME PHONE #

Address:_____
STREET CITY STATE ZIP CODE

Who referred you to our office?_____

Was referral by a physician? ❑ Yes ❑ No If yes, please provide referring physician's name and address:

_____
LAST FIRST CITY STATE

INSURANCE INFORMATION

Primary

Insurance Co.: _____

_____

Policy #:_____

Group #: _____

Name of Policy Holder:_____

SS# of Policy Holder:_____

Date of Birth of Policy Holder:_____

Your Relationship to Insured:
❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

Secondary

Insurance Co.: _____

_____

Policy #:_____

Group #: _____

Name of Policy Holder:_____

SS# of Policy Holder:_____

Date of Birth of Policy Holder:_____

Your Relationship to Insured:
❑ Self ❑ Spouse ❑ Dependent ❑ Other _____

CONTINUED ON NEXT PAGE

YOUR VISION

Are you interested in receiving information about laser vision correction for improving your vision without glasses or contacts?

❑ Yes ❑ No

Do You Wear Contact Lenses?

❑ Yes ❑ No

Do You Sleep in Your Contact Lenses?

❑ Yes ❑ No

Do You Wear Glasses?

❑ Yes ❑ No

Age of Present Glasses: _____

When do you wear glasses or contacts?

❑ Reading

❑ Distance

❑ Computers

❑ Sports

❑ Playing Musical Instruments

Other: _____

_____

Who is your eye doctor?

_____

PATIENT AGREEMENT

I understand that payment is due at the time of service. I certify that the information provided on this form is correct.
I authorize the release of information including medical information to this organization and all insurance organizations involved with my claim.
I authorize my physician to prescribe medication and to give me reasonable and proper medical care by today's standards.

(SEAL)

_____
SIGNATURE

_____
DATE

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Washington Eye Physicians and Surgeons, P.C. for any services provided to me by the physicians.
I authorize any holder of medical information about me to release it to the Health Care Financing Administration and its agents when it is needed to determine these benefits or benefits payable for related services.

_____
SIGNATURE

_____
DATE

CONTINUED ON NEXT PAGE

HEALTH INFORMATION

Date: _____

Patient Name: _____
LAST FIRST M.I.

Primary Care Physician: _____
LAST FIRST CITY STATE

Primary Care Physician Telephone Number: _____

Pharmacy's Name: _____

Pharmacy's Phone Number: _____

Pharmacy's Address: _____
CITY STATE ZIP CODE

Check box if you have any of the following symptoms:

- ❑ Vision problems while driving, reading or watching TV
- ❑ Blurred or distorted vision
- ❑ Flashes of light
- ❑ Webs or spots in your vision
- ❑ Light sensitivity
- ❑ Double vision
- ❑ Eye pain
- ❑ Foreign body sensation
- ❑ Redness
- ❑ Tearing, itching or burning
- ❑ Lumps or growths around the eyes
- ❑ Drooping eyelids
- ❑ Headache
- ❑ Discharge
- ❑ Other _____
  _____
  _____

SOME EYE AND OTHER CONDITIONS CAN RUN IN FAMILIES

Do you have a family history of (if yes, who):

- ❑ Cataracts _____
- ❑ Glaucoma _____
- ❑ Macular Degeneration _____
- ❑ Blindness _____
- ❑ Other Eye Diseases _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Hypertension _____
- ❑ Migraines _____
- ❑ Thyroid Disease _____
- ❑ Arthritis _____
- ❑ Cancer _____

CONTINUED ON NEXT PAGE

PERSONAL HISTORY (use back of page if needed)

Have you ever been treated for any of the following medical conditions?

- ❑ Cataracts
- ❑ Diabetes
- ❑ Diabetic Retinopathy
- ❑ Dry Eyes
- ❑ Eye Injury
- ❑ Glaucoma
- ❑ Kerataconus
- ❑ Lazy Eye / Cross-Eye
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Asthma
- ❑ Angina
- ❑ Arthritis
- ❑ Blood Disorder
- ❑ Cancer
- ❑ Cardiovascular Disease
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Lupus
- ❑ Migraines
- ❑ Pneumonia
- ❑ Thyroid Disease
- ❑ Other _____

_____

Do you take any eye medications? ❑ Yes ❑ No

If yes, please list:_____

Do you take any other medications, vitamins or herbal supplements? ❑ Yes ❑ No

If yes, please list:_____

_____

Do you have any drug allergies? ❑ Yes ❑ No

If yes, please list:_____

Have you ever had any eye surgeries? ❑ Yes ❑ No

If yes, please list, including dates:_____

In the past ten years, have you been hospitalized or had other surgery? ❑ Yes ❑ No

If yes, please list with dates: _____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

SOCIAL HISTORY

Do you smoke? ❑ Yes ❑ No If yes, how much?_____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much?_____

Do you exercise regularly? ❑ Yes ❑ No

REVIEW OF SYSTEMS

Do you currently have any of the following problems:

	YES	NO
Fatigue, unexpected weight loss/gain, chronic fever	❑	❑
Ear / nose / throat problems (sinus, sore throat)	❑	❑
Respiratory problems (shortness of breath, wheezing)	❑	❑
Heart problems (chest pains, irregular heart beat)	❑	❑
Gastrointestinal problems (heartburn, abdominal pain)	❑	❑
Urinary problems (pain, discomfort, blood in urine)	❑	❑
Musculoskeletal problems (joint pain, muscle aches)	❑	❑
Skin problems (excessive dryness, rashes)	❑	❑
Neurologic problems (headaches, paralysis, numbness)	❑	❑
Psychiatric problems (depression, anxiety)	❑	❑

PLEASE SEND ME MORE INFORMATION ABOUT:

	YES	NO
Laser Vison Correction or LASIK	❑	❑
Keratoconus or Corneal Cross-linking	❑	❑
Advanced Cataract treaments	❑	❑
Botox, Juvederm, or Latisse	❑	❑
Ocular/Facial cosmetic procedures and treatments	❑	❑

First Review:_____Date: _____

Second Review: _____Date: _____

Third Review:_____Date: _____