PATIENT REGISTRATION FORM

Name (First/M./Last)_____ Date _____

Gender: _____ Birth Date_____ Marital Status

SSN _____ Driver's License Number_____ Expiration Date_____

Address (No P.O. Boxes) _____

City_____State_____Zip_____

Mailing Address (if different from above)_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Preferred Method of Contact :

Preferred Language _____ Email_____

Race: Please select from drop down all that apply: American Indian/ Alaska Native
Asian

Ethnicity Hispanic/Latino
Native Hawaiian/Polynesian

Were you referred by your doctor? Doctor's Name _____

How did you choose us? _____

Employer_____ Occupation_____

Address _____

City _____ State_____ Zip_____

PRIMARY INSURED'S INFORMATION

Name(First/M./Last)_____ Birth Date _____

Occupation_____ SSN _____

Employer _____ Address_____

City _____ State _____ Zip _____

EMERGENCY CONTACT INFORMATION

Name (First/M./Last)_____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Alternate Contact Name (First/M./Last) _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

MEDICAL HISTORY / REVIEW OF SYSTEMS

Name: _____ Height _____ Weight _____

Primary M.D. _____ Do you have any allergies to medications? Y ☐ N ☐

	Y	N	
Do you have any non-medication allergies?	☐	☐	To what? _____
Do you smoke? (circle):	☐	☐	How Much? _____
Do you consume alcoholic beverages? (circle)	☐	☐	How Much?_____

Have you had or have any problems with the following? **(Check all that apply)**

Cancer ☐
Cardiovascular ☐
Constitutional ☐
Ear/Nose/Mouth/Throat ☐
Endocrine/Diabetes ☐
Gastrointestinal ☐
Genitourinary ☐
Hematologic (Blood) ☐
Hepatitis ☐
High Blood Pressure ☐
HIV/Aids ☐
Immunological ☐
Integumentary (Skin) ☐
Musculoskeletal ☐
Neurological ☐
Psychiatric ☐
Respiratory ☐
Stroke ☐

Please Explain _____

_____

Do you have any family members with the following? **(Please only list blood related, immediate family members)**

☐ Diabetes	Relation: _____	☐ Glaucoma	Relation: _____
☐ High Blood Pressure	Relation: _____	☐ Cataracts	Relation: _____
☐ Cancer	Relation: _____	☐ Crossed Eye	Relation: _____

Please provide a list of the following (leave blank if the answer is none)

Medications _____

_____

Medication Allergies _____

_____

Eye Surgeries _____

_____