Albertville eye care
Personal Attention, Professional Care.

PATIENT REGISTRATION & MEDICAL HISTORY FORM

First Name: _____ Last Name: _____ MI: ___ Preferred Name: _____

Date of Birth: ___/___/_____ Sex: M / F Referred by: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Home / Cell / Work Secondary Phone: _____ Home / Cell / Work

E-mail Address: _____ Spouse (or Parent's) Name: _____

Name of Employer or School: _____ Occupation: _____

Primary Medical Insurance: _____ Vision Insurance: _____

Name of Insured: _____ Date of Birth: ___/___/____ Relationship to Patient: _____

Insured's Social Security Number: _____ Insured's Employer: _____

*A copy of all insurance cards is required on the day of service.

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Albertville Eye Care's statement on privacy practices.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize IFE - MN, INC to release any medical or incidental information that may be necessary for processing applications for financial benefit.
CONSENT FOR TREATMENT: I hereby authorize IFE - MN, INC to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand any remaining balance on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any reasonable costs associated with the collection past-due balances.

Patient/Guardian Signature: _____ Date: ___/___/_____

Primary Reason for Visit

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover your exam if there is a medical reason for the visit such as headache, eye pain, eye itching or burning, dry eyes, glaucoma, cataract, etc.

□ Blurred Vision	□ Itchy Eyes	□ Aching Eyes	□ Night Vision Problems
□ Distorted Vision	□ Burning Eyes	□ Excessive Squinting	□ Light Sensitivity
□ Double Vision	□ Dry Eyes	□ Seeing Rings Around Lights	□ Floating Spots
□ Red Eyes	□ Painful Eyes	□ Losing Place While Reading	□ Flashing Lights
□ Watery Eyes	□ Discharge From Eyes	□ Other _____	

History of the Symptoms

Which eye has the problem? □ Right □ Left □ Both
How is it affecting you? □ Bothersome □ Aware □ Painful
How severe is the problem? □ Mild □ Moderate □ Severe
How long have you had the problem? _____

Is the problem □ New □ Ongoing □ Returning
Associated with: □ Infection □ Medical Condition □ Injury □ Surgery
Previous treatment? □ Drops □ Medication □ Other: _____
Associated symptoms: □ Headache □ Other: _____

Family History

Has anyone in your family been diagnosed with any of the following? (check all that apply)
□ No problems □ Diabetes □ High Blood Pressure □ Heart Disease □ Cancer

Has anyone in your family been diagnosed with any of the following eye problems? (check all that apply)
□ No Problems □ Cataracts □ Corneal Disease □ Lazy Eye □ Retinal Disease □ Glaucoma □ Macular Degeneration

(See Reverse)

Social History

Do you use tobacco products? □ Y □ N If yes, type/amount/how long? _____

Do you drink alcohol? □ Y □ N If yes, type/amount/how long? _____

Do you use illegal drugs? □ Y □ N if yes, type/amount/how long? _____

Review of Systems - Do you or have you ever experienced any problems in the following areas?

Constitutional		**Endocrine**		**Gastrointestinal**	
Fever / Weight Gain/Loss	□ Y □ N	Non-Insulin Dependent Diabetes	□ Y □ N	Crohn's	□ Y □ N
		Insulin Dependent Diabetes	□ Y □ N	Colitis	□ Y □ N
Integumentary		Thyroid Dysfunction	□ Y □ N	Ulcer	□ Y □ N
Eczema	□ Y □ N	Hormonal Dysfunction	□ Y □ N	Digestive	□ Y □ N
Psoriasis	□ Y □ N				
Cancer	□ Y □ N	**Respiratory**		**Genitourinary**	
		Asthma	□ Y □ N	Genitals / Kidney / Bladder	□ Y □ N
Neurological		Chronic Bronchitis	□ Y □ N		
Headaches	□ Y □ N	Emphysema	□ Y □ N	**Allergy / Immunological**	
Migraines	□ Y □ N	Cancer	□ Y □ N	Environmental Allergy	□ Y □ N
Seizures	□ Y □ N			Rheumatoid Arthritis	□ Y □ N
Multiple Sclerosis	□ Y □ N	**Cardiovascular**		Lupus	□ Y □ N
Cancer	□ Y □ N	High Blood Pressure	□ Y □ N		
		High Cholesterol	□ Y □ N	**Psychiatric**	
Ear / Nose / Throat		Stroke	□ Y □ N	Depression	□ Y □ N
Allergies / Hay Fever	□ Y □ N	Heart Disease	□ Y □ N	Panic Disorder	□ Y □ N
Sinus Congestion	□ Y □ N			Schizophrenia	□ Y □ N
Chronic Cough	□ Y □ N	**Lymphatic / Hematological**			
Dry Throat / Mouth	□ Y □ N	Bleeding Problems	□ Y □ N	**Pregnant / Nursing**	□ Y □ N

List all medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies):

_____

List any allergies to medications: _____

List any other allergies: _____

Hobbies / Recreation / Sport

□ Boating □ Fishing □ Gardening □ Photography □ Sewing □ Card Playing □ Crafts □ Golf

□ Flying □ Swimming □ Scuba Diving □ Racquetball □ Biking □ Hunting □ Music □ Skiing

Current Vision

Glasses: Do you currently wear glasses? □ Y □ N If yes, age of current glasses? _____

What type of lenses are in your glasses? □ Single Vision □ Bifocal □ Trifocal □ No-line (Progressive) □ N/A

Contact Lenses: Do you currently wear contact lenses? □ Y □ N If no, continue to Lifestyle Section below.

What type of contact lenses do you wear? □ Soft □ Rigid Gas Permeable Are they comfortable? □ Y □ N

What brand of contacts do you wear? _____

How often do you replace your contacts? □ Daily □ 1-2 Weeks □ Monthly □ 3 Months □ 6 months □ Yearly

How old is your current pair of contacts? _____

What solutions do you use to care for your contacts? □ Renu □ Opti-Free □ Clear Care □ Other: _____

Lifestyle

Are your eyes sensitive to sunlight?	□ Y □ N	Do you work at a computer?	□ Y □ N
Do you have problems with reflections or glare?	□ Y □ N	Are there times when you prefer not to wear your	□ Y □ N
Are you interested in new contact lens technology?	□ Y □ N	glasses?	