STAFF INITIALS ________

PATIENT REGISTRATION FORM

DATE ______________

NAME: FIRST ______________________ MI _____ LAST ________________________ AGE _____ SEX: M/F

PREFERRED NAME _______________________ HOME PHONE________________________

BIRTH DATE _____/____/______ CELL PHONE ________________________

ADDRESS ____ APT# ______________

CITY ___________________________ STATE _____ ZIP _________________ SSN ______ - ___ - ______

E-MAIL ADDRESS ____

EMPLOYER ________________________________ OCCUPATION __________________________________

MARITAL STATUS: SINGLE MARRIED PARTNER WIDOWED DIVORCED

PHARMACY _____________________ PHONE NUMBER____

Insurance Information (Disregard for LASIK/PHAKIC Patients)

PRIMARY INSURANCE ________________________________ PHONE NUMBER ______________________

NAME OF INSURED ___________________________ RELATIONSHIP TO PATIENT ___________________

ID# ____ GROUP#___________________________________

DATE OF BIRTH _________________________ SSN ______ - ___ - _______

SECONDARY INSURANCE _____________________________ PHONE NUMBER ______________________

NAME OF INSURED ___________________________ RELATIONSHIP TO PATIENT ___________________

ID# ____ GROUP#___________________________________

DATE OF BIRTH _________________________ SSN ______ - ___ - _______

Emergency Contact

FULL NAME _________________________________ RELATIONSHIP TO PATIENT ___________________

PHONE NUMBER ______________ ADDRESS ____

HIPAA Contact List

SightTrust and its associates and staff have my permission to speak to the following family members/friends in reference to my medical care:

FULL NAME __________________________________ RELATIONSHIP TO PATIENT ___________________

FULL NAME __________________________________ RELATIONSHIP TO PATIENT ___________________

FULL NAME __________________________________ RELATIONSHIP TO PATIENT ___________________

WHOM MAY WE THANK FOR THIS REFERRAL? ____

SIGHT TRUST
EYE INSTITUTE

HEALTH HISTORY

PATIENT NAME:____ DATE: ___________________

Past Medical History

Please check off if you have been diagnosed with any of the following:

- ☐ Anxiety/ Depression
- ☐ Migraines/Headache
- ☐ Diabetes (Insulin use? _______)
- ☐ Carotid Artery Disease
- ☐ Heart Disease: Pacemaker/ Defibrillator/ Arrhythmia/ Stents
- ☐ Hypertension
- ☐ Heart Attack/ MI/ TIA
- ☐ Neurological Disease
- ☐ Seizures / Stroke
- ☐ COPD / Sleep Apnea/ CPAP
- ☐ Shortness of Breath
- ☐ Asthma (Inhaler use? ________)
- ☐ Lung Disease
- ☐ Prostate Disease (meds for prostate or hair growth? ________)
- ☐ Cancer
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV/AIDS
- ☐ Autoimmune Disorder
- ☐ Other: ______________________

Past Ocular History

Please check off if you have been diagnosed with any of the following:

- ☐ Amblyopia
- ☐ Cataract
- ☐ Dry Eye(s)
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Corneal Disease: Keratoconus
- ☐ Crossed Eyes
- ☐ Injury/ Abrasion
- ☐ Iritis
- ☐ Other Eye Disorders: _______________________

Past Ocular Surgeries

- ☐ Cataract
- ☐ LASIK/ PRK/ RK
- ☐ Plastic Surgery (Blepharoplasty)
- ☐ Glaucoma Surgery
- ☐ Retina Surgery
- ☐ Other Ocular Surgery: _______________________

Please list all Allergies/reactions

No Known Allergies/ Latex Allergy/ Iodine Allergy/ Sulfa Allergy

Allergies: ____

Please list all current medications: *Prescribed and over the counter*

____

____

Please list all previous surgeries/procedures (including year):

____

____

List anyone in your immediate family who has the following:

(Mother, Father, Sister, Brother)

- ☐ Macular Degeneration
- ☐ Corneal Disease
- ☐ Glaucoma
- ☐ Other Ocular Disease:______________________

Social History:

- ☐ Smoke: No / Yes _____ packs per day/week/month/socially
- ☐ Alcohol: No / Yes _____ drinks per day/week/month/socially