madison vision clinic

Patient Registration Form

DATE:_____

Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. This information is required and is kept strictly confidential.

SECTION 1 - GENERAL INFORMATION

First Name :_____ **Last Name**:_____ **Middle Init.**_____ **Preferred Name**:_____

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

Birthdate: _____/_____/_____ **Sex**: ☐ M ☐ F **Marital Status**: ☐ Single ☐ Married ☐ Other

Occupation:_____ **Employer/School**:_____

SSN#_____ **Insurance:** ***Please present Medical & Vision cards.***

SECTION 2 - CONTACT INFORMATION

Phone numbers: Home #_____ **Work #**_____ **Cell #**_____

Email Address:_____ **Preferred method of contact?**_____

Emergency Contact: Name _____ **Relationship to you**?_____ **Phone #**_____

Name of Responsible Party (if minor):_____ **Relationship**:_____

SECTION 3 – PATIENT MEDICAL INFORMATION

Name of family doctor:_____ **Clinic:** _____ **Pharmacy**:_____

Have you had any surgeries, major injuries or hospitalizations? Y / N If Yes, please list:_____

Allergies: ☐ None ☐ Yes, to what?_____

Do you use cigarettes? Y / N Tobacco? Y / N Alcohol? Y / N Illegal Drugs? Y / N How Much?_____

Please circle the conditions below that you have or see a doctor for. If it doesn't apply, place an 'X' in the NA box.

Allergic/Immune ☐ NA Allergies (Seasonal/environment) Lupus Rheumatoid Arthritis Sjogren's Syndrome	**Blood/Lymph** ☐ NA Anemia High Cholesterol Leukemia Other _____	**Cardiovascular** ☐ NA Heart disease High Blood Pressure Stoke/CVA Vascular Disease	**Constitutional** ☐ NA Developmental Disability Fever Weight loss
Ear/Nose/Throat ☐ NA Dry mouth Hearing loss Sinusitis Other_____	**Endocrine** ☐ NA Diabetes: ☐ Non-insulin dependent ☐ Insulin-dependent Hormone Dysfunction Thyroid (Hypo/Hyper)	**Genitourinary** ☐ NA Kidney Disease Prostate Disease/Cancer STD Other_____	**Gastrointestinal** ☐ NA Acid Reflux Celiac Disease Colitis / Crohn's Disease IBS (Irritable Bowel Syndrome) Ulcer
Ocular (Eye) ☐ NA Cataracts Glaucoma Macular Degeneration Strabismus (Eye Turn) Amblyopia (Lazy Eye) Other_____	**Musculoskeletal** ☐ NA Arthritis Fibromyalgia Ankylosing Spondylitis Muscular Dystrophy Osteoarthritis Osteoporosis	**Neurological** ☐ NA Alzheimer's Cerebral Palsy Epilepsy Migraines Multiple Sclerosis (MS) Parkinson's	**Psychiatric** ☐ NA ADHD Anxiety Autism Spectrum Disorder Bipolar Disorder Depression
Respiratory ☐ NA Asthma COPD Emphysema Sleep apnea TB (Tuberculosis)	**Skin** ☐ NA Eczema Psoriasis Rosacea Shingles Other _____	**Other (Please List)**	

SECTION 4 – FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following medical conditions? (check all that apply) ☐ **No Problems**

☐ **Heart Disease** _____ ☐ **Diabetes**_____ ☐ **High Blood Pressure** _____ ☐ **Cancer** _____ ☐ **Other**

Has anyone in your family been diagnosed with any of the following eye conditions? (check all that apply) ☐ **No problems**

☐ **Glaucoma** _____ ☐ **Macular Degeneration** _____ ☐ **Cataracts** _____ ☐ **Amblyopia (lazy eye)** _____

☐ **Strabismus (eye turn)** _____ ☐ **Retinal Detachment** _____ ☐ **Other** _____

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Patient Medical/Vision History Form DATE:_____

Please fill out or review this form in its entirety. If you have questions we will be glad to help you. This information is required and is kept strictly confidential.

REASON FOR VISIT

How can we help you today? In this space please check/explain any signs and/or symptoms you are currently experiencing.

- ☐ **Routine check up**
- ☐ **Blurred vision**
- ☐ **Burning/itching**
- ☐ **Crossed eyes**
- ☐ **Double vision**
- ☐ **Dry eyes**
- ☐ **Eye pain/soreness**
- ☐ **Floaters/Flashes of light**
- ☐ **Glare**
- ☐ **Light sensitivity**
- ☐ **Loss of vision**
- ☐ **Red eyes**
- ☐ **Sandy/gritty Feeling**
- ☐ **Tired eyes**
- ☐ **Watery eyes**
- ☐ **Want new contacts**
- ☐ **Want new glasses**
- ☐ **Other: (please explain)**_____

_____

PATIENT'S CURRENT MEDICAL/VISION INFORMATION

Current medication(s) and/or supplement(s): ☐ None ☐ Yes (please list)_____

_____

_____

Are you currently pregnant? Y / N ☐ NA **Are you currently nursing?** Y / N ☐ NA

Current eye drop(s): ☐ None ☐ Yes (please list)_____

Last Eye Exam: _____ **Where**:_____ **Do you currently wear glasses?** Y / N

Contact Lenses (please skip if you do not wear contact lenses)

Do you wear contact lenses? Y / N ➔ If yes, are they ☐ soft ☐ Rigid/Gas permeable Do you sleep in your lenses? N / Y

How old is your current pair of contacts?_____ weeks / months / years

How often do your replace your lenses? ☐ daily ☐ weekly ☐ 2 weeks ☐ monthly ☐ other:_____

What is the brand?_____ **What are the powers of your lenses**? **RT**:_____ **LT**:_____

What solutions do you use? ☐ **Optifree** _____ ☐ **Renu** ☐ **Biotrue** ☐ **Clear Care** ☐ **Other**:_____

NOTICE OF PRIVACY PRACTICES: I have been shown or offered a copy Madison Vision Clinic's statement on privacy policies that is displayed at their front desk and on their website.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Madison Vision Clinic to release any medical or incidental information that may be necessary for medical benefit in processing applications for financial benefit. This includes, but is not limited to, my insurance company, rehabilitation services, social security administration, and worker's compensation.

CONSENT FOR TREATMENT: I hereby authorize Madison Vision Clinic 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, co-pay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider. I understand that any remaining balance on my account after 30 days will accrue monthly interest charges and that I will be responsible for any reasonable costs associated with the collection of past-due balances.

I acknowledge that all the above information is correct and current.

_____ _____ _____ _____

SIGNATURE **If Pers. Rep. is signing please list relationship to patient** **DATE**

☐ **Reviewed** _____ _____ **Changes made?** ☐ N ☐ Y (list)_____ _____ _____
INITIAL **DATE**

☐ **Reviewed** _____ _____ **Changes made?** ☐ N ☐ Y (list)_____ _____ _____
INITIAL **DATE**

☐ **Reviewed** _____ _____ **Changes made?** ☐ N ☐ Y (list)_____ _____ _____
INITIAL **DATE**