Park Avenue Optometry inc.

REGISTRATION FORM

(please print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	Birth date: / /	Age:	**Sex:** ☐ M ☐ F

Street address: City: State: ZIP Code:

Home phone no:	Cell phone no:	Social Security no:

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorce ☐ Widowed

Occupation:	Employer:	Work phone no.:

Email address:	Would you like to receive reminders via Email? ☐ Yes ☐ No

How did you choose our clinic (please check box)?

☐ Employer ☐ Insurance ☐ Family Member ☐ Friend ☐ Internet ☐ Other

RESPONSIBLE PARTY ☐ Self

Person responsible for bill: (if different from above)	Birth date: / /	Address (if different):	Home phone no.:

Occupation:	Employer:	Work phone no.:

Is this person a patient here? ☐ Yes ☐ No

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ medicare ☐ medi-cal ☐ VSP ☐ IEHP ☐ MESC ☐ EyeMed ☐ Avesis ☐ Davis vison ☐ Optum Health ☐ NVA ☐ superior vision plan

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance: (if applicable)	Subscriber's name:	Birth date: / /	Group no.:	Policy no.:

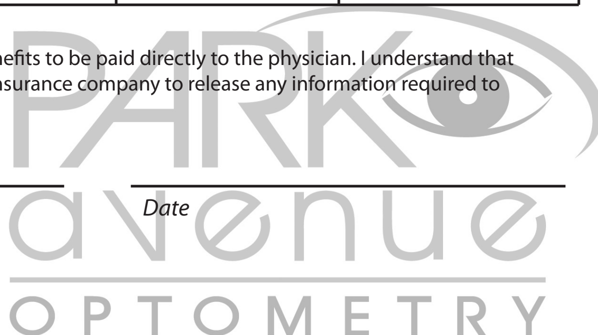
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of friend of relative (not living at same address):	Relationship to patient:	Home phone no.:	Cell phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Park Avenue Optometry or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*



PATIENT HISTORY QUESTIONNAIRE

Today's Date: Date of last eye exam: Dilated? Y / N

Last name: First name: MI:

MEDICAL INFORMATION

What is your general health?______________________________

List all major injuries, surgeries, and/or hospitalizations you have had ____________________________________

____

____

____

Are you pregnant and/or nursing? Y / N

Do you wear glasses? Y / N If yes, how old is your present pair of lenses?________________

Do you wear contact lenses? Y / N If yes, how old is your present pair of lenses?________________

REVIEW OF SYSTEMS

Do you currently, or have you ever had, any problems in the following areas:

Constitutional

Fever, Weight Loss/Gain Y / N

Integumentary (Skin) Y / N

Neurological

Headaches Y / N

Migraines Y / N

Seizures Y / N

Eyes

Loss of Vision Y / N

Blurred Vision Y / N

Distorted Vision/Halos Y / N

Loss of Side Vision Y / N

Double Vision Y / N

Dryness Y / N

Mucous Discharge Y / N

Redness Y / N

Sandy or Gritty Feeling Y / N

Itching Y / N

Burning Y / N

Excess Tearing/Watering Y / N

Glare/Light Sensitivity Y / N

Eye Pain or Soreness Y / N

Chronic Infection of Eye or Lid Y / N

Flashes/Floaters in Vision Y / N

Endocrine

Thyroid/Other Glands Y / N

Allergic/Immunologic Y / N

Psychiatric Y / N

Ear, Nose, Mouth, Throat

Allergies/Hay Fever Y / N

Sinus Congestion Y / N

Runny Nose Y / N

Post-Nasal Drip Y / N

Chronic Cough Y / N

Dry Throat/Mouth Y / N

Respiratory

Asthma Y / N

Chronic Bronchitis Y / N

Emphysema Y / N

Vascular/Cardiovascular

Diabetes Y / N

Heart Pain Y / N

High Blood Pressure Y / N

Vascular Disease Y / N

Gastrointestinal

Chronic Diarrhea Y / N

Chronic Constipation Y / N

Genitourinary

Genitals/Kidney/Bladder Y / N

Bones/Joints/Muscles

Rheumatoid Arthritis Y / N

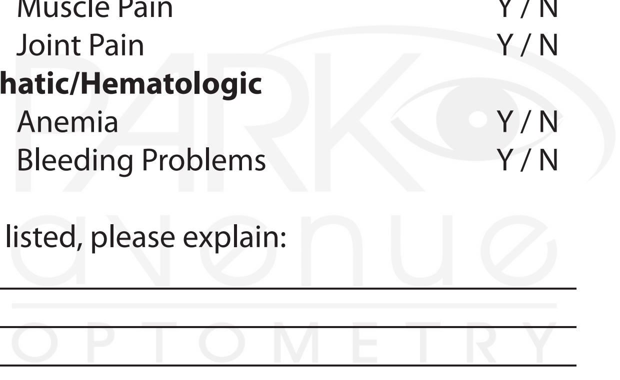
Muscle Pain Y / N

Joint Pain Y / N

Lymphatic/Hematologic

Anemia Y / N

Bleeding Problems Y / N



If you answered yes to any of the above, or have a condition not listed, please explain:

____

____

____

MEDICATIONS

Do you have any allergies to medication? Y / N If yes, explain_______________

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

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social history information directly with the doctor.

Do you drive? Y / N If yes, do you have visual difficulty when driving? Y / N If yes, please describe:_______________

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_______________

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition		**Relationship**
Blindness	Y / N	
Cataract	Y / N	
Crossed Eyes	Y / N	
Glaucoma	Y / N	
Muscular Degeneration	Y / N	
Retinal Detachment/Disease	Y / N	
Arthritis	Y / N	
Cancer	Y / N	
Diabetes	Y / N	
Heart Disease	Y / N	
High Blood Pressure	Y / N	
Kidney Disease	Y / N	
Lupus	Y / N	
Thyroid Disease	Y / N	
Other	Y / N	

Doctor Use Only

Reviewed by_______________ Changes Yes / No Date_______________

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