SHORELINE EYE GROUP PATIENT REGISTRATION

PATIENT_____

ADDRESS_____
Street/P.O. city state zip

EMAIL_____DATE OF BIRTH_____AGE_____

SOCIAL SECURITY #_____LANGUAGE_____

GENDER_____M_____F ETHNICITY(optional)_____RACE_____

PRIMARY PHONE #_____ BUSINESS PHONE #_____

MARTIAL STATIS_____ CELL PHONE #_____

EMERGENCY CONTACT PERSON_____

TELE#_____RELATIONSHIP_____

PERSON RESPONSIBLE FOR BILL_____

ADDRESS_____

TELE #_____RELATIONSHIP_____

HOW DID YOU HEAR ABOUT SHORELINE EYE GROUP?_____

INDICATE BELOW THE FORMS RECEIVED, REVIEWED AND/ OR COMPLETED PRIOR TO YOUR APPOINTMENT:

_____ I HAVE BEEN OFFERED A COPY OF THE SHORELINE EYE GROUP P.C.'S NOTICE OF PRIVACY PRACTICES

_____I HAVE READ, UNDERSTAND AND AGREE TO COMPLY WITH THE SHORELINE EYE GROUP, P.C.'S INSURANCE FINANCIAL POLICIES

_____I HAVE COMPLETED A MEDICAL HISTORY FORM

_____I HAVE SUBMITTED CURRENT INSURANCE INFORMATION

I authorize payment of medical insurance benefits to be made directly to SHORELINE EYE GROUP.
I understand that I am financially responsible for all charges not paid by my insurance, to include any procedure that is not covered by my insurance plan.

SIGNATURE_____DATE_____

If Guarantor, relationship to patient_____

Rev12/2015

Shoreline Eye Group Medical History Questionnaire

Patient name: _____ Today's date: _____

Date of Birth_____ Who is your medical doctor? _____

Do you wear Glasses □ yes □ no Contact Lenses □ yes □ no

What is the main reason for your visit today? _____

DO YOU HAVE ANY OF THESE EYE SYMPTOMS?

- □ Blurred distance vision
- □ Blurred reading vision
- □ Constant double vision
- □ Flashing lights or floaters
- □ Red eyes
- □ Headaches
- □ Glare, halos around lights
- □ Itching or burning eyes
- □ Eye mattering or tearing
- □ Foreign body sensation
- □ Dry eye
- □ Eye pain

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS INCLUDING OVER THE COUNTER MEDICATION OR LATEX?

□ None known □ Yes, which ones?

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____

WHICH EYE MEDICATIONS OR OTHER EYE DROPS DO YOU CURRENTLY TAKE?

□ None □ Artificial Tears

Medication Name	How many times/day
_____	1 2 3 4 at bedtime
_____	1 2 3 4 at bedtime
_____	1 2 3 4 at bedtime
_____	1 2 3 4 at bedtime
_____	1 2 3 4 at bedtime

WHICH OTHER MEDICATIONS OR SUPPLEMENTS DO YOU CURRENTLY TAKE?

□ None □ Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

HAVE YOU EVER HAD ANY OF THESE EYE PROBLEMS?

- □ Cataract
- □ Glaucoma
- □ Macular degeneration
- □ Lazy eye / patched as a child
- □ Other:_____
- □ Serious eye injury
- □ Iritis / uveitis
- □ Lid lesions
- □ Retinal detachment
- □ Eye surgery

HAVE YOU EVER HAD ANY OF THESE CONDITIONS?

- □ None □ Lyme disease □ Auto immune disease
- □ Stroke □ Dizziness □ High blood pressure
- □ Arthritis □ Allergies □ Heart disease
- □ Diabetes □ AIDS, HIV □ Lung disease
- □ Cancer □ Hepatitis C □ Thyroid disease
- □ Migraines □ MRSA □ Prostate
- □ Other: _____

HAVE MEMBERS OF YOUR FAMILY HAD ANY EYE DISEASES?

(This would be your father, mother, sister, brother, and grandparents)

- □ Glaucoma □ Diabetic eye disease or diabetes
- □ Cataract □ Crossed eyes □ Macular degeneration
- □ Iritis / uveitis □ Blindness □ Retinal detachment
- □ Poor vision □ Other: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

□ None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please Proceed to Other Side

Shoreline Eye Group Medical History Questionnaire

LIST NON-SURGICAL ILLNESSES REQUIRING HOSPITALIZATION _____

_____

_____

REVIEW OF SYSTEMS:

(Are you currently experiencing any of the following symptoms?)

□ No □ Yes Chronic fever, fatigue, weight loss _____

□ No □ Yes Ears, nose, throat problems _____

□ No □ Yes Cardiovascular (blood pressure, pulse) _____

□ No □ Yes Respiratory (asthma, cough) _____

□ No □ Yes Gastrointestinal (nausea, vomiting, bowel problem) _____

□ No □ Yes Kidney, bladder, genital problems _____

□ No □ Yes Muscles, joints, bones (arthritis, pains) _____

□ No □ Yes Skin (rashes, moles) _____

□ No □ Yes Neurological (headache, weakness) _____

□ No □ Yes Psychiatric (anxiety, depression, insomnia) _____

□ No □ Yes Endocrine (diabetes, thyroid) _____

□ No □ Yes Blood (anemia, bleeding problems) _____

Other _____

SOCIAL HISTORY

Occupation _____

If you are a student, what grade? _____

Do you smoke? □ No □ Yes, how much? _____

Do you drink alcohol? □ No □ Yes, how much? _____

Signature _____ Date: _____

Relationship to Patient _____

Reviewed date	Initials	Reviewed date	Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments: _____