# Reed Family Vision Patient Registration

Patient Name:_____ Age: _____ Date of Birth: _____/_____/_____ Gender: M or F
Street Address:_____ City:_____ State_____ Zip:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Permission to receive text? Yes or No E-mail:_____
Patient's Social Security Number:_____-_____-_____
Employer:_____ Occupation:_____
Patient's Primary Care Physician: _____ Phone number:_____
How did you hear about our office?_____

**Insurance Information**
Primary Cardholder:_____ Primary's Date of Birth:_____/_____/_____
Insurance Name:_____ ID number: _____ Group number:_____

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any services rendered. I certify the above information is correct. I understand updates of my personal information are needed for quality care.

**Patient History**
Your main reason for today's exam?_____
_____
Age of your presents glasses?_____ Last exam date?_____ From doctor?_____

**Dilation Consent**:
Since our office is committed to the prevention of disease, we recommend dilation of the eyes as part of every examination. Dilation is the use of drops to temporarily enlarge the pupils, which allows the doctor to fully examine the retina and inner eye. Dilation is recommended for all new patients, people with a history of headaches, diabetes, high blood pressure, high cholesterol, glaucoma, high prescriptions, and past eye problems. Most people experience an increased sensitivity to light and decreased near vision for up to 6 hours after dilation. Driving is usually not impaired, but may require extra attention.

_____ **YES** – I give consent for my eyes to be dilated today.
_____ **NO –** I decline having my eyes dilated today. I understand the importance of dilation, and release Reed Family Vision Center for any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by the completion of dilation. **Initials: _____**

Have you ever had any of the following conditions involving your eyes?

| | | | |
|---|---|---|---|
| _____Poor Distance Vision | _____Watering | _____Dry Eyes | _____Flashes of Light |
| _____Poor Near Vision | _____Headaches | _____Floaters / Spots | _____Eye Surgery |
| _____Burning | _____Eye Strain | _____Double Vision | _____Eye Injury |
| _____Itching | _____Eye Infection | _____Loss of Vision | _____Light Sensitivity |

Do you or anyone in your immediate family have a history of the following? If so, **who**?

| | | |
|---|---|---|
| Glaucoma_____ | Turned or lazy eye_____ | High blood pressure_____ |
| Cataracts_____ | Thyroid disease_____ | Heart Condition_____ |
| Retinal Disease_____ | Arthritis_____ | Diabetes_____ |
| Blindness_____ | Respiratory Problems_____ | Cancer_____ |

Do you use cigarettes and/or tobacco? Yes / No Are you pregnant or nursing? Yes / No
Do you currently take any medication? Yes / No If so, please list all medications:
_____

Do you have any allergies to any medication? Yes / No If so, please list the drugs you are allergic to:
_____
Have you ever worn contacts? Yes / No Are you interested in obtaining contact lenses? Yes / No
How often do you replace your contacts?_____ Do you sleep in your contacts? Yes / No

**I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**