Registration / Medical History

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.

DATE:_____ ***SECTION 1 - GENERAL INFORMATION (DEMOGRAPHICS)*** ***Entered into record*** ☐

Legal First Name:_____ Last Name:_____ Middle Init.____ Preferred Name: _____

Address:_____City:_____State:_____Zip:_____

Birthdate:_____ Sex: ☐ M ☐ F Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed

Occupation:_____ Employer/School:_____

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

SECTION 2 - CONTACT INFORMATION (DEMOGRAPHICS) ***Entered into record*** ☐

Preferred Phone:_____ (☐ Home ☐ Cell ☐ Work) Alternate Phone # :_____

Email Address:_____

(NOTE: By providing your email address you giving consent to receive emailed appointment reminders and recalls.)

Emergency Contact (Name, Relationship, Phone)_____

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

SECTION 3 – (PRIMARY CARE PROVIDER / PHARMACY / EYE SURGERIES) ***Entered into record*** ☐

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

Have you had any eye surgeries? ☐N ☐Y - If yes, Type:_____When?_____

Which eye? _____ Provider/Surgeon:_____

SECTION 4 - REVIEW OF SYSTEMS – (ENCOUNTER - HISTORY)

Do you have any problems or see a doctor for any of these systems? (Please circle N or Y - <u>If yes, please circle the condition listed</u>)

Constitutional - **N / Y** (Developmental Disability, Cancer, Fatigue Syndrome, Other _____)
Ear/Nose/Throat **N / Y** (Hearing Loss, Sinusitis, Dry Mouth, Laryngitis, Other _____)
Neurological **N / Y** (MS, Epilepsy, Cerebral Palsy, Tumor, Migraines, Parkinson's Other _____)
Psychiatric **N / Y** (Depression, ADHD, Anxiety, Bipolar Disorder, Autism Spectrum Disorder, Other _____)
Cardiovascular **N / Y** (Hypertension (HBP), Stroke / CVA, Heart Disease, Vascular Disease, Congestive Heart Failure)
Respiratory **N / Y** (Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstructive (COPD), Sleep Apnea)
Gastrointestinal **N / Y** (Crohn's / Colitis, Ulcer, Acid Reflux, Celiac Disease, IBS (Irritable Bowel Syndrome, Other _____)
Genitourinary **N / Y** (Kidney Disease, Prostate Disease / Cancer, STD _____, Other _____)
Musculoskeletal **N / Y** (Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout)
Integ. (Skin) **N / Y** (Eczema, Rosacea, Psoriasis, Herpes Simplex / Cold Sores, Herpes Zoster / Shingles, Other _____)
Endocrine **N / Y** (Diabetes - ☐ Type 1 ***OR*** ☐ Type 2**,** Thyroid Dysfunction, Hormone Dysfunction)
Blood/Lymph **N / Y** (Anemia, Large Volume Blood Loss, High Cholesterol, Leukemia, Hepatitis ___, Other _____)
Allergic/Immune **N / Y** (Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, AIDS)
Ocular / Eyes **N / Y** (Cataracts, Glaucoma, Macular Degeneration, Strabismus (Eye Turn), Amblyopia (Lazy Eye)

Are you currently pregnant? N / Y **If yes, are you nursing?** Y / N

Current medication(s) and/or supplement(s): ☐ None ☐Yes (If yes, please present a list or list here) _____

_____

Current eye drop(s): ☐ None ☐Yes (If yes, please list type) _____

Allergies: ☐ None ☐Yes – to what?_____

SOCIAL Do you use cigarettes? Y / N Tobacco? Y / N Alcohol? Y / N Illegal drugs? Y / N

CONTINUED ON BACK ----------→

SECTION 5 – FAMILY HISTORY

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

☐ **Cancer** (Mother / Father / Sibling / Child) ☐ **Diabetes** (Mother / Father / Sibling / Child)

☐ **Hypertension (HBP)** (Mother / Father / Sibling / Child)

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

☐ **Macular Degeneration** (Mother / Father / Sibling / Child) ☐ **Cataracts** (Mother / Father / Sibling / Child)

☐ **Glaucoma** (Mother / Father / Sibling / Child) ☐ **Amblyopia** (Mother / Father / Sibling / Child)

☐ **Retinal Detachment** (Mother / Father / Sibling / Child) ☐ **Strabismus (eye turn)** (Mother / Father / Sibling / Child)

PATIENT'S CURRENT VISION INFORMATION

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

Do you wear Contact Lenses? N (skip to next section) / Y (if yes, type? ☐ Soft ☐ Rigid / Gas permeable)

Brand?_____ **Do you know your powers of your lenses?** RT: _____ LT: _____

Do you sleep in your contacts? N / Y **How often do you replace your lenses?** ☐ Daily ☐ Weekly ☐ 2 Weeks ☐ Monthly

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

REASON FOR VISIT

How can we help you today? ☐ Routine Eye Exam **Do you have any concerns?**_____

Please check any signs or symptoms you are currently experiencing below.

☐ Blurred Vision	☐ Burning / Itching	☐ Crossed eyes	☐ Double Vision	☐ Dry eyes
☐ Floaters/Flashes of light	☐ Glare	☐ Light sensitivity	☐ Red eyes	☐ Eye pain/soreness
☐ Sandy/gritty feeling	☐ Tired eyes	☐ Watery eyes	☐ Loss of Vision	☐ Other _____

NOTICE OF PRIVACY PRACTICES: I have been shown or offered a copy of 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 & INSURANCE CLAIMS: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. Sending a claim to your insurance does NOT guarantee payment. Your insurance company makes the final coverage determinations after a claim is received. All payments are subject to your policy terms and conditions. You are responsible for any services not covered by your insurance such as any deductible, or co-pays. If you know you have a high deductible, you may want to pay your charges out-of-pocket and receive our Time of Service (TOS) discount. You must notify our office upon arrival if there have been any changes to your insurance coverage so that we may obtain current benefit information at that time. We will not file a claim to your insurance if you opt to pay for your visit with the Time of Service (TOS) discount.

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 collection of past-due balances.

I acknowledge that all the information on this Registration / Medical History form is correct and current.

_____ _____ ____/____/_____

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