Registration

Name:_____Age_____ Date of Birth_____
First Middle Last

Address_____City_____Zip_____

Home Phone_____Cell_____Work_____

Social Security Number_____Occupation_____

Email address_____

Place of Work_____Allergies_____

Spouse and children's names_____

Internist or family doctor_____Who referred you here?_____

Name and date of birth of insurance card holder_____

Please check or list your medial problems: Asthma___Diabetes___High Blood Pressure___
Emphysema___Heart Disease___Arthritis___Thyroid___Anemia___Bronchitis___
Migraine___Cancer___Other_____

Do you smoke?Yes___No___If yes how many packs/day?___

Do you have any unusual dietary habits? Yes__No___Explain_____

Please check your eye problems: Cataract___Glaucoma___Double Vision___Blurry Vision___
Tearing___Itching___Burning___Retinal Degeneration___Floater___Flashes___Red eyes___
Other(please list)_____

Please List Your Medications:_____

Do you have vision coverage separate from medical health insurance? Yes___No___

Please be sure to give us your insurance cards to copy.

X_____
Signature as consent for the office to submit insurance claims for you