

REGISTRATION FORM

PATIENT NAME: _____

ADDRESS (STREET, CITY, STATE, ZIP): _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____ OCCUPATION: _____

DATE OF BIRTH: ____/____/____ AGE: _____ SEX: _____

SOCIAL SECURITY NUMBER: _____ MARITAL STATUS: _____

NAME OF SPOUSE/GUARDIAN/PARENT: _____

PRIMARY CARE PHYSICIAN – ADDRESS & TEL: _____

REFERRED BY: _____

PREFERRED PHARMACY- NAME, ADDRESS & TEL: _____

PRIMARY INSURANCE: _____ INSURED NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

INSURED SEX: ____ DATE OF BIRTH: ____/____/____ SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT (SPOUSE/GUARDIAN/OTHER): _____

INSURED'S EMPLOYER: _____

SECONDARY INSURANCE: _____ INSURED NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

INSURED SEX: ____ DATE OF BIRTH: ____/____/____ SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT (SPOUSE/GUARDIAN/OTHER): _____

INSURED'S EMPLOYER: _____

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY

Date _____

Patient Name: _____

Do you wear glasses? _____

Do you wear contact lenses? _____

Check box if you have any of the following symptoms:

- Vision problems while driving, reading, or Watching TV
- Blurred or distorted vision
- Flashes of light
- Webs or spots in your vision
- Light sensitivity
- Double vision
- Eye pain

- Foreign body sensation
- Redness
- Tearing, itching, or burning
- Lumps or growths around the eyes
- Drooping eyelids
- Headache
- Discharge
- Other _____

PERSONAL HISTORY

Have you ever been treated for any of the following medical conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Asthma / Lung Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Angina | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Raynaud's Syndrome |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Lazy/Crossed Eye | <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> High Cholesterol | _____ |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Low Blood Pressure | _____ |

Do you take any eye medications?

Yes No

If yes, please list: _____

Do you take any other medications or herbal supplements?

Yes No

If yes, please list: _____

Do you have any drug allergies or allergies to eye drops?

Yes No

If yes, please list: _____

Have you ever had any eye surgeries or laser treatments?

Yes No

If yes, please list, including dates: _____

In the past ten years have you been hospitalized or had other surgery?

Yes No

If yes, please list, including dates: _____

Patient Name: _____

FAMILY HISTORY

Do you have a family history of any of the following medical conditions? (If yes, who)

- Glaucoma _____
- Cataracts _____
- Macular Degeneration _____
- Arthritis _____
- Cancer _____

- Diabetes _____
 - Heart Disease _____
 - Hypertension _____
 - Migraines _____
 - Thyroid Disease _____
-

SOCIAL HISTORY

Do you or did you every smoke? Yes No (Never smoked)

If yes, how much?

- Current every day smoker
- Current some day smoker
- Former smoker

Do you drink alcohol? Yes No If yes, how much? _____

Do you exercise regularly? Yes No

RACE AND ETHNICITY

What race do you consider yourself?

- American Indian
- Asian
- Black
- Native Hawaiian
- White
- Other _____

What ethnicity do you consider yourself? Hispanic

- Non-Hispanic Origin
- Other _____

What is your primary language? English

Other _____

I prefer not to disclose my race, ethnicity and/or primary language

REVIEW OF SYSTEMS

Do you currently have any of the following problems?

- | | | |
|--|------------------------------|-----------------------------|
| Fatigue, unexpected weight loss/gain chronic fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear/ nose/ throat problems (sinus, sore throat) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Respiratory problems (shortness of breath, wheezing) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart problems (chest pains, irregular heart beat) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Gastrointestinal problems (heartburn, abdominal pain) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Urinary problems (pain, discomfort, blood in urine) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Musculoskeletal problems (joint pain, muscle aches) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin problems (excessive dryness, rashes) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological problems (headaches, paralysis, numbness) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Psychiatric problems (depression, anxiety) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient Lifestyle Questionnaire

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us to better understand your vision care needs.

What is your professional environment? (Check all that apply)

- I work in a professional business office. My job requires travel (driving/flying/both).
 I work from home. I work outside most of the time.

How much time do you spend each day at a computer?

- 0-1 hour 1-2 hours 3-5 hours 5+ hours

How much time do you spend driving at night? (Hours/minutes) _____

What type of outdoor activities do you participate in? (Check all that apply)

- Boating Biking Golfing Gardening Hiking Skiing Team Sports

What are your indoor hobbies?

- Arts/Crafts Reading Scrapbooking Sewing Other _____

Please list any skin allergies: _____

Are you concerned about protecting your eyes from harmful UV rays? Yes No

What do you currently use for sunwear? _____

What did you like about your last pair of glasses? _____

What would you change? _____

What did you like about your last pair of sunglasses? _____

What would you change? _____

Do you currently wear Progressive lenses, are you happy with them? Yes No

Office Use Only

Vision Care Recommendations:

Frames _____ Lenses _____ Sunglasses _____ Contacts _____ Other _____

MEDICATION HISTORY RELEASE

I hereby permit Eye Care Associates to download my medication history for the next two years for the purposes of practicing medicine.

Responsible Party's Name

Responsible Party's Signature

Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)/MEDICAL RECORDS

I hereby give my consent for **Eye Care Associates/Glaucoma Consultants of Long Island** to use and disclose protected health information about me in order to carry out treatment, payment, and healthcare operations.

With this consent, **Eye Care Associates/Glaucoma Consultants** may call my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results.

With this consent, **Eye Care Ophthalmology/Glaucoma Consultants** may mail to my home or other alternative location any items that assist the practice, such as appointment reminders and patient statements.

Patient’s Name **Signature of Patient or Legal Guardian** **Date**

BENEFITS RELEASE

Authorization to release:

I hereby authorize Drs. Prywes, Weinstein, Marcus, Rothman, Angelilli, Serle, Hayes and/or Auerbach to furnish my insurance company all information that the insurance company may request concerning my present claim.

Assignment of Benefits:

I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to the doctor. I understand that any monies received from my insurance company over and above my indebtedness will be refunded to me when my account is paid in full. I understand that I am financially responsible to the doctors for fees.

Responsible Party’s Name **Responsible Party’s Signature** **Date**