College Point Optometric Associates

Patient Registration Form

Name: _____
(Last) (First) (MI)

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work/Cell: _____

Emergency contact: _____ Phone: _____

Relationship: _____

Vision Insurance: _____ Policy number: _____

Policy holder name: _____ Date of birth: _____

Relationship to patient: _____

Medical Insurance: _____ Policy number: _____

Policy holder name: _____ Date of birth: _____

Relationship to patient: _____

Assignment of benefits:

I hereby assign or transfer payment benefits made to me and my behalf to College Point Optometric Associates, PC, for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

Release of information:

I hereby authorize College Point Optometric Associates, PC, to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor, or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

Privacy:

I acknowledge that I have received College Point Optometric's Notice of Privacy Practices and I understand my rights set forth within this notice.

Patient signature: _____ **Date:** _____

Medical History Questionnaire

Patient Information

Today's Date: _____
Patient Name: _____
Sex ◻ M ◻ F Date of birth: _____
Occupation: _____
Primary Care doctor: _____

Eye History

Reason for today's visit: _____
_____

Last eye exam: _____

Do you currently wear glasses?
◻ All the time ◻ Reading/computer
◻ Distance

Do you currently wear Contact Lenses? ◻ Y ◻ N
If yes, what type? _____
Are you happy with your lenses? ◻ Y ◻ N
If no, are you interested in Contacts? ◻ Y ◻ N

Please indicate if you have any of the following:
◻ Blurred distance vision
◻ Blurred near vision
◻ Burning, itching, or red Eyes
◻ Eye pain
◻ Discharge from eyes
◻ Double vision
◻ Floaters
◻ Flashes of light
◻ Headaches
◻ Loss of vision
◻ Light sensitivity
◻ Injury to eyes
◻ Eye turn/lazy eye
◻ Glaucoma
◻ Macular degeneration
◻ Cataracts
◻ Other eye disease (explain) _____

Have you ever had any injuries or surgeries on your eyes?
_____
_____

Please indicate any family history of the following:
◻ Cataracts ◻ Eye turn ◻ Glaucoma ◻ Retinal disease
◻ Macular degeneration ◻ Blindness ◻ Diabetes
◻ High blood pressure ◻ Cancer ◻ Heart disease

Are you pregnant or nursing? ◻ Y ◻ N
Do you smoke? ◻ Y ◻ N
Do you use illegal drugs? ◻ Y ◻ N
Do you drink alcohol? ◻ Y ◻ N

Review of Systems

Please indicate if you currently or have ever had any of these conditions:

Constitutional
◻ Fever ◻ Weight loss/gain
Neurological
◻ Headaches ◻ Migraines ◻ Seizures
Endocrine
◻ Thyroid condition
Ear, Nose, Throat
◻ Allergies/hay fever ◻ Sinus congestion
◻ Runny nose/post-nasal drip
◻ Dry throat/mouth ◻ Chronic cough
Respiratory
◻ Asthma ◻ Emphysema ◻ Sleep apnea
Vascular/Cardiovascular
◻ Diabetes ◻ High blood pressure ◻ Heart disease
◻ Other vascular disease
Bones/Joints/Muscles
◻ Rheumatoid arthritis ◻ Muscle pain ◻ Joint pain
Lymphatic/Hematologic
◻ Anemia ◻ Bleeding problems
Immunologic
◻ Cancer ◻ HIV

Please list all prescription and over the counter medications that you take, including eye drops, topical creams, and nasal sprays or inhalers:
_____
_____
_____
_____
_____
_____
_____
_____

Please list any allergies you have: ◻ No known allergies
_____
_____

Please list any major surgeries you've had:
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

We are pleased to announce the introduction of secure online services through our Patient Portal. The Patient Portal is an interactive, secure patient website that allows you to communicate with our office via the web. These services will help us correspond securely, keep your information up to date and are available from the comfort of home.

In order for you to access our Patient Portal, we need you to fill out the bottom of this page. A valid email address is required to access the Patient Portal.

Print Patient Name: _____

Date of Birth: _____

Email Address: _____

If the email listed is a patient representative email such as a parent, please fill out:

Name: _____

Relationship to patient: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____

Address: _____ Fax: _____

PRIMARY/REFERRING PHYSICIAN

Primary Physician name: _____ Phone: _____

Address: _____ Fax: _____

Referring Physician name: _____ Phone: _____

Address: _____ Fax: _____