



Gleneagle Vision Center, P.C. Registration Form

Patient Information

Patient's Legal Name: _____ Suffix: _____ Today's Date: _____

Nick Name: _____ Sex: M F Title: Mr. Ms. Mrs. Miss

Date of Birth: _____ Age: _____ SS# (for billing purposes): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Email: _____

Preferred Contact (circle one): Cell Home Email Other _____

Insurance Information

Primary Medical Insurance: _____

Subscriber Name: _____ Date of Birth: _____

SS# (for billing purposes): _____ Policy #: _____ Group # (optional): _____

Relationship to Subscriber (circle one): Self Spouse Child Other _____

Secondary Medical Insurance: _____

Subscriber Name: _____ Date of Birth: _____

SS# (for billing purposes): _____ Policy #: _____ Group # (optional): _____

Relationship to Subscriber (circle one): Self Spouse Child Other _____

Vision Insurance (circle one): VSP EYEMED

Subscriber Name: _____ Date of Birth: _____

SS# (for billing purposes): _____ Policy #: _____ Group # (optional): _____

Relationship to Subscriber (circle one): Self Spouse Child Other _____

Release of Information

I authorize the release of information (including the diagnosis, records, examination rendered to me and claims information) to be released to the following*:

Spouse: _____ Other: _____

Child(ren): _____ **DO NOT** release my information to anyone

Messages

If unable to reach me:

You may leave a detailed message

You may leave a brief message asking for a call back

*The release information and method to reach me will remain in effect until terminated by me in writing.

Patient/Guardian Signature: _____ Date: _____

Gleneagle Vision Center, P.C.
Medical Questionnaire

Name: _____ Date: _____

Reason for Visit:

- General Eye Exam General Eye Exam with Contacts Lens Fitting/Evaluation
- Evaluation after Trauma/Brain Injury/Concussion/Stroke/Neurological Reason
- Referral from- _____
- Other _____

Do you wear glasses? Yes No Do you wear Contacts? Yes No
Type of Contacts: Soft Other

Date of Last Eye Exam: _____ Eye Doctor: _____
Last Medical Exam: _____ Primary Care Physician: _____

Medical History

Current Medications: including contraceptives, over the counter, supplements, vitamins:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medications? Yes No If yes, _____

List any major injuries/motor vehicle accidents/concussions/surgeries/hospitalizations with dates:

Are you pregnant or nursing? Yes No

Social History

Do you drive? Yes No Is driving difficult? Yes No
Do you use any tobacco products (circle one)? >1 year 1-5 years <5-10 years Occasional Never
Do you consume alcohol (circle one)? Occasional Frequent Never
Do you use any recreational drugs (circle one)? Occasional Frequent Never
Have you ever been exposed to or infected with: AIDS/HIV Gonorrhea Hepatitis Syphilis None

Hobbies/Sports: _____
Occupation: _____

I would prefer not to discuss my social history.

Review of Systems

Do you currently, or have you ever had problems in the following areas?

Constitutional

Yes No Fever, weight gain/loss
Ear/Nose/Throat

Yes No Sinus Congestion

Yes No Dry mouth/throat

Cardiovascular

Yes No Heart Pain

Yes No High blood pressure

Yes No Vascular disease

Yes No Heart surgery

Respiratory

Yes No Asthma

Yes No Chronic bronchitis

Yes No Emphysema

Genitourinary

Yes No Dialysis/kidney failure

Gastrointestinal

Yes No Diarrhea

Yes No Constipation

Musculoskeletal

Yes No Rheumatoid arthritis

Yes No Muscle pain

Yes No Joint Pain

Integumentary (Skin)

Yes No Eczema

Yes No Skin cancer

Yes No Sinus Congestion

Neurological

Yes No Headaches

Yes No Migraines

Yes No Concussion

Yes No Stroke

Psychiatric

Yes No Depression

Yes No Anxiety

Endocrine

Yes No Diabetes

Yes No Hyper/Hypo thyroid

Hematologic/Lymphatic

Yes No Anemia

Yes No Bleeding problems

Allergic/ Immunologic

Yes No Lupus

Yes No Hay fever/allergies

Please explain if you have answered yes to any of the conditions above or have any conditions not listed:

Ocular History

Yes No Glaucoma

Yes No Cataracts

Yes No Diabetic Retinopathy

Yes No Retinal Disease

Yes No Eye Injury

Yes No Blindness

Yes No Cross/turned eye

Yes No Lazy eye/amblyopia

Yes No Keratoconus

Yes No Decreased vision

Yes No Dry eyes

Yes No Burning eyes

Yes No Itching eyes

Yes No Double vision

Yes No Eye pain

Yes No Floaters

Yes No Flashes of light

Yes No LASIK/other eye surgeries

Please explain if you have answered yes to any of the conditions above or have any conditions not listed:

Family History

Blindness Yes No

Cataract Yes No

Glaucoma Yes No

Macular Degeneration Yes No

Retinal Detachment Yes No

Cancer Yes No

Diabetes Yes No

Heart Disease Yes No

High Blood Pressure Yes No

Unknown Family History

Relationship
