TWINSBURG Eye Associates

PATIENT REGISTRATION AND MEDICAL HISTORY FORM

☐ New Patient ☐ Returning patient

First Name:_____ Middle Initial:_____ Last Name:_____ Preferred Name:_____

Birth Date:_____ Social Security Number:_____ Sex: **M** / **F**

Home Address:_____ City:_____ State:_____ ZIP:_____

Which phone number would you prefer we use to contact you? **Home** **Work** **Cell** Home Phone:_____ Work Phone:_____

Cell Phone:_____ E-mail Address:_____

Please give all insurance cards to the receptionist to copy on the day of service

Primary Medical Insurance:_____ Secondary Medical Insurance:_____

Vision Insurance:_____ Insured's Birth Date:_____

Insured's Employer:_____

Prmary Care Doctor:_____

NOTICE OF PRIVACY PRACTICES: I have been offered a copy of Twinsburg Eye Associates' statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Twinsburg Eye Associates to release any medical or incidental information that may be necessary for medical benefit of 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.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at a later date.

Due to changes in insurance regulations, if you have both a vision plan and a medical insurance plan, we are now required to coordinate your benefits with both plans. If you are being seen for a medical problem, or if you have any medical conditions that can affect the eyes or vision, your medical insurance will be billed first. Some of these medical conditions include: macular degeneration, diabetes, high blood pressure, blurred vision, glaucoma, flashes, floaters, rosacea, eye pain, itchy eyes, Bell's Palsy, double vision, allergies, foreign body, eye trauma, corneal ulcers, eye injury, swollen eyelids, headaches, chalazion, dry eye, red eyes, stye, drooping eyelids, "pink eye", burning eyes, shingles, etc. If you are here for a comprehensive, or annual, exam, we must now submit the eyeglass prescription determination portion of the visit to your vision plan after submitting any medical claim to your medical insurance plan. You may still use vision plan materials benefits, if eligible, at the time of your exam.

CONSENT FOR TREATMENT: I hereby authorize Twinsburg Eye Associates to administer diagnostic and medical procedures as may be necessary for proper health care.

SIGNATURE:_____ DATE:_____ Relationship to patient: **Self** **Parent/Guardian** **Other**:

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing:

☐**Loss of vision**	☐**Floaters**	☐**Eye pain/soreness**	☐**Glare**	☐**Dry Eyes**
☐**Blurred vision**	☐**Crossed Eyes**	☐**Watery Eyes**	☐**Light sensitivity**	☐**Red Eyes**
☐**Double vision**	☐**Flashes of light**	☐**Sandy/gritty feeling**	☐**Tired Eyes**	☐**Itching/burning**

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* ☐**Right** ☐**Left** ☐**Both**
Quality *How is it affecting you?* ☐**Bothersome** ☐**Aware** ☐**Painful**
Severity *How severe is the problem?* ☐**Mild** ☐**Moderate** ☐**Severe**
Duration *How long have you had the problem?*_____

Timing *Is it new, ongoing, returning?* ☐**New** ☐**Ongoing** ☐**Returning**
Context *Associated with:* ☐**Infection** ☐**Medical condition** ☐**Injury** ☐**Surgery**
Modifiers *Previous treatment?* ☐**Drops** ☐**Medication** ☐**Other:**
Symptoms *Are there associated symptoms?* ☐**Headache** ☐**Other:**

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
☐**No Problems** ☐**Diabetes** ☐**High Blood Pressure** ☐**Cancer** ☐**Glaucoma** ☐**Amblyopia** ☐**Cataracts** ☐**Macular Degeneration**
☐**Strabismus** (eye turn)

PLEASE CONTINUE TO OTHER SIDE ----------→

SOCIAL HISTORY

Do you smoke? ☐Y ☐N
If yes, what do you smoke? ☐Cigarettes ☐Cigars ☐Pipes
How much per month do you smoke?_____

Do you consume alcohol? ☐Y ☐N
If yes, how much do you drink?_____

What is your occupation / grade?_____ Employer / School:_____

REVIEW OF SYSTEMS

Allergy/Immunologic Problems			**Genitourinary Problems**			Epilepsy	**Y**	**N**
Environmental allergies	**Y**	**N**	Prostate disease/cancer	**Y**	**N**	**Neurological Problems (cont.)**		
Rheumatoid arthritis	**Y**	**N**	STD	**Y**	**N**	Other		
Drug allergies	**Y**	**N**	Kidney disease	**Y**	**N**	**Psychiatric Problems**		
Lupus	**Y**	**N**	Other			Depression	**Y**	**N**
Other			**Ear, Nose, Mouth Throat Problems**			Anxiety	**Y**	**N**
Cardiovascular Problems			Laryngitis	**Y**	**N**	Other		
Vascular disease	**Y**	**N**	Dry mouth	**Y**	**N**	**Respiratory Problems**		
Stroke	**Y**	**N**	Hearing loss	**Y**	**N**	Emphysema	**Y**	**N**
Congestive heart failure	**Y**	**N**	Sinusitis	**Y**	**N**	Bronchitis	**Y**	**N**
Heart Disease	**Y**	**N**	Other			Smoker	**Y**	**N**
High Blood Pressure	**Y**	**N**	**Blood/Lymph Problems**			COPD	**Y**	**N**
Other			Large volume blood loss	**Y**	**N**	Asthma	**Y**	**N**
Constitutional Problems			Anemia	**Y**	**N**	Other		
Cancer	**Y**	**N**	Other			**Ocular/Eye Problems**		
Fatigue	**Y**	**N**	**Skin Problems**			Inflammatory disorder	**Y**	**N**
Developmental disability	**Y**	**N**	Rosacea	**Y**	**N**	Surgery	**Y**	**N**
Other			Psoriasis	**Y**	**N**	Glaucoma	**Y**	**N**
Endocrine Problems			Eczema	**Y**	**N**	Amblyopia (lazy eye)	**Y**	**N**
Insulin-dependent diabetes	**Y**	**N**	Other			Cataract	**Y**	**N**
Hormonal dysfunction	**Y**	**N**	**Musculoskeletal Problems**			Retinal problems	**Y**	**N**
Thyroid dysfunction	**Y**	**N**	Ankylosing spondylitis	**Y**	**N**	Macular degeneration	**Y**	**N**
Non-insulin diabetes	**Y**	**N**	Fibromyalgia	**Y**	**N**	Strabismus (eye turn)	**Y**	**N**
Other			Muscular dystrophy	**Y**	**N**	Patching	**Y**	**N**
Gastrointestinal Problems			Osteoarthritis	**Y**	**N**	Other		
Colitis	**Y**	**N**	Other					
Crohn's disease	**Y**	**N**	**Neurological Problems**					
Ulcer	**Y**	**N**	Cerebral Palsy	**Y**	**N**			
Other			Multiple sclerosis	**Y**	**N**			
			Tumor	**Y**	**N**			

CURRENT VISION

Glasses: Do you currently wear glasses? ☐**Y** ☐**N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses **Single vision** **Bifocal** **Trifocal** **Progressive (no-line)**

Contact Lenses: Do you currently wear contact lenses? ☐**Y** ☐**N** *if yes, answer the questions below; if no, continue to lifestyle section*
What type of contact lenses do you wear? **Soft** **Rigid**
What is the manufacturer of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____
How often do you replace your contact lenses? _____
What solutions do you use to care for your contact lenses? **Renu** **Optifree** **Clear Care** **Sauflon** **Boston** **Optimum** **Other:**_____

Lifestyle Questions:

Do you sometimes experience dry eyes?	**Y**	**N**
Are your eyes sensitive to sunlight?	**Y**	**N**
Do you work at a computer?	**Y**	**N**
Do you have problems with reflections and/or glare?	**Y**	**N**
Do you prefer not to wear your glasses at times?	**Y**	**N**
Are you interested in newer contact lens technology?	**Y**	**N**
Do you want information on thinner / lighter lenses?	**Y**	**N**
Do you want information on LASIK vision surgery?	**Y**	**N**
Would you be interested in a non-surgical option to LASIK?	**Y**	**N**
Do you have any children?	**Y**	**N**
Do you spend time outdoors?	**Y**	**N**

HOW DID YOU FIRST HEAR ABOUT OUT OFFICE?

☐ **INTERNET WEBSITE** ☐ **DIRECT MAIL**
☐ **ANOTHER DOCTOR**_____
☐ **INSURANCE PROVIDER**_____
☐ **ANOTHER PATIENT**_____

Please list your sporting activities / hobbies:_____
List any medications you are currently taking:_____
List any medicine allergies:_____
List any other allergies:_____