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Lifetime Eye Care Patient Registration Form

Name____Date________________

Street____City________________State________Zip______

Birthdate________________ Sex ☐ M ☐ F Marital Status ☐ Married ☐ Single ☐ Other

Home Phone________________________Cell Phone______________________Work Phone______________________

Email____Last 4 of Social _______________

How did you hear about our office? ☐ Newspaper ☐ Insurance ☐ Family Doctor ☐ Saw building

☐ Friend / Family ___________________________

Date of Last Eye Exam_________________________________ Date of Last Medical Exam____________________

Do you wear glasses? ☐ Y ☐ N Contact Lenses ☐ Y ☐ N

Are you interested in Contact Lenses today? ☐ Y ☐ N

Reason for today's appointment____

Are you using insurance for today's appointment? ☐ Y ☐ N

Vision Insurance Company___________________________ Medical Insurance Company_______________________

Primary Insured's Name____________________________Primary Insured's Date of Birth____________________

Medical History

Do you have any problems with any of these systems? (*check box for all that apply)*

☐ Gastrointestinal ☐ Nervous ☐ Eyes ☐ Endocrine ☐ Ears/Nose/Throat ☐ Kidney

☐ Musculoskeletal ☐ Mental ☐ Skin ☐ Headaches ☐ Allergic/Immune ☐ Lung

☐ Genitourinary ☐ Blood ☐ Weight Loss/Gain ☐ Diabetes ☐ Y ☐ N Type ☐ I ☐ II

Other Health Conditions: ____

Do you use cigarettes / tobacco? ☐ Y ☐ N Do you use Alcohol? ☐ Y ☐ N Other Substances ☐ Y ☐ N

Medications: ____

Medication Allergies:____ Seaonal Allergies ☐ Y ☐ N

Patient/Guardian Signature: ____

Provider Reviewed: _____________________________________ Date Reviewed:_______________________________