Patient Registration & Insurance Information

Please also complete back of form.

Please print legibly.

Patient's Information				
Name			Today's Date	
Street			Birth Date	
City		State	Zip	
Occupation				
Home/Business Phone ( )		Mobile Phone ( )		
Email address				
Have you ever been examined in this office? YES NO				
Whom may we thank for referring you to us?				
Please indicate:	❑Married	❑Single	❑Other	
Please indicate:	❑F/T Student	❑P/T Student	❑Not a Student	
Please indicate:	❑Employed Full Time	❑Employed Part Time	❑Retired	❑Not Employed
Relation to Insured	❑Self	❑Spouse	❑Dependent	
Insured's Information				
Name				
Street			Birth Date	
City		State	Zip	
Home/Business Phone ( )		Mobile Phone ( )		
Please indicate:	❑Married	❑Single	❑Other	
Please indicate:	❑F/T Student	❑P/T Student	❑Not a Student	
Please indicate:	❑Employed Full Time	❑Employed Part Time	❑Retired	❑Not Employed
Vision Insurance Plan				
❑EyeMed	❑Davis Vision	❑Superior Vision	❑NVA	❑VSP
❑Other (please indicate):				❑None

HIPAA Privacy Practices

If you would like a copy of the Notice of Privacy Practices, please ask an associate.

I acknowledge that I have been offered a copy of the **Notice of Privacy Practices** of Dr. Schrier. Additionally, I authorize the payment of any eye care benefits or insurance to Dr. Schrier. I understand that I may have copayments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred.

_____ _____

Patient's Signature or Patient's Legal Representative Date

Please also complete back of form.

Patient Eye & Health History

What is your main reason for coming in today?				
❑Routine Eye Exam	❑Poor Distance Vision	❑Poor Near Vision	❑Dry Eyes	❑Headache
❑Itching	❑Bloodshot Eyes	❑Burning Eyes	❑Watering	❑Eye Strain
❑Twitching Eyelid	❑Flashes of Light	❑New Floaters	❑Infection	❑Injury
❑Poor Night Vision	❑Other			
Have you been examined in this office? YES NO	Date of last exam:			
Do you wear glasses? YES NO	If YES indicate use:			
Do you wear contact lenses? YES NO				
Are you pregnant or nursing? YES NO				

Do you currently experience…					
Blurred distance vision	YES NO	Tearing	YES NO	Spots / floaters	YES NO
Blurred near vision	YES NO	Itching	YES NO	Flashes of light	YES NO
Eyestrain	YES NO	Burning	YES NO	Headaches	YES NO
Double vision	YES NO	Sensitivity to light	YES NO		
Other symptoms:					

Eye History: Do you have or did you have…					
Eye infections	YES NO	Cataracts	YES NO	Glaucoma	YES NO
Eye surgery	YES NO	Macular degeneration	YES NO	Iritis	YES NO
Dry eyes	YES NO	Retinal hole / tear	YES NO	Crossed eye	YES NO
Lazy eye	YES NO	Retinal detachment	YES NO	Eye injuries	YES NO
Other eye history:					

Medical History: Do you have or did you have…					
Diabetes	YES NO	Thyroid disease	YES NO	Seasonal Allergies	YES NO
High blood pressure	YES NO	Arthritis	YES NO	Asthma	YES NO
High cholesterol	YES NO	Migraines	YES NO	Sinus problems	YES NO
Heart disease	YES NO				
Other medical history:					

Please list current medications...
If <u>none</u>, check here: ❑

Please list drug allergies...
If <u>none,</u> check here: ❑

Family History: Has a FAMILY MEMBER had…					
High blood pressure	YES NO	High cholesterol	YES NO	Glaucoma	YES NO
Heart disease	YES NO	Thyroid disease	YES NO	Cataracts	YES NO
Diabetes	YES NO	Macular degeneration	YES NO	Arthritis	YES NO
Notes:					

Reviewed by Doctor:_____ Date:_____