

# 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: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	
Please indicate: <input type="checkbox"/> F/T Student <input type="checkbox"/> P/T Student <input type="checkbox"/> Not a Student	
Please indicate: <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	
Relation to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	

## Insured's Information

Name	Birth Date
Street	Birth Date
City	State      Zip
Home/Business Phone (      )	Mobile Phone (      )
Please indicate: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	
Please indicate: <input type="checkbox"/> F/T Student <input type="checkbox"/> P/T Student <input type="checkbox"/> Not a Student	
Please indicate: <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Not Employed	

## Vision Insurance Plan

<input type="checkbox"/> EyeMed	<input type="checkbox"/> Davis Vision	<input type="checkbox"/> Superior Vision	<input type="checkbox"/> NVA	<input type="checkbox"/> VSP
<input type="checkbox"/> Other (please indicate):				<input type="checkbox"/> 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?

<input type="checkbox"/> Routine Eye Exam	<input type="checkbox"/> Poor Distance Vision	<input type="checkbox"/> Poor Near Vision	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Headache
<input type="checkbox"/> Itching	<input type="checkbox"/> Bloodshot Eyes	<input type="checkbox"/> Burning Eyes	<input type="checkbox"/> Watering	<input type="checkbox"/> Eye Strain
<input type="checkbox"/> Twitching Eyelid	<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> New Floaters	<input type="checkbox"/> Infection	<input type="checkbox"/> Injury
<input type="checkbox"/> Poor Night Vision	<input type="checkbox"/> 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 none, check here:**

## Please list drug allergies...

**If none, 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: \_\_\_\_\_

# **PATIENT PRE-SCREENING QUESTIONNAIRE**

We appreciate your cooperation and patience in helping to keep our patients and staff safe and healthy.

Have you traveled outside the U.S. in the past 30 days? YES NO

If yes, where? \_\_\_\_\_

Have you traveled to a U.S. City/State with reported cases of Coronavirus in the past 30 days? YES NO

If yes, where? \_\_\_\_\_

Have you been in personal contact with a person infected with Coronavirus or who has traveled to an area with widespread and ongoing transmission of Coronavirus in the past 30 days? YES NO

## **IN THE LAST 48 HOURS:**

Have you had a fever (99.5°+)? YES NO

Have you experienced any:

Coughing? YES NO

Sore Throat? YES NO

Difficulty Breathing? YES NO

Muscle Aches? YES NO

Stomach Pain? YES NO

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*Please return this form to the front desk when completed\*\***



### Insurance Information

*Please note: Medical insurance does not generally cover routine eye examinations. If there is a MEDICAL diagnosis, we may be able to bill your medical insurance.*

*We accept many vision plans, such as EyeMed, Davis, NVA, and Superior just to name a few.*

#### **Primary Insured's Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_

=====  
**Patient's Relation to Insured** (Circle One)    Insured    Spouse    Dependent    Other  
=====

#### **Primary Medical Insurance Information**

Insurance Name \_\_\_\_\_

ID Number \_\_\_\_\_

#### **Secondary Medical Insurance Information**

Insurance Name \_\_\_\_\_

ID Number \_\_\_\_\_

#### **Optical or Vision Plan Information**

Plan Name \_\_\_\_\_

ID Number \_\_\_\_\_