AV EYE CARE REGISTRATION AND HISTORY FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	SEX	TODAY'S DATE
		M F	

ADDRESS (INCLUDING APT OR STE #)	MARITAL STATUS
	SINGLE MARRIED WIDOWED DIVORCED

CITY	STATE	ZIP CODE		AGE	DATE OF BIRTH

PRIMARY PHONE NUMBER	CIRCLE ONE	EMAIL ADDRESS
	HOME CELL WORK	
OTHER PHONE NUMBER	CIRCLE ONE	SOCIAL SECURITY NUMBER
	HOME CELL WORK	

OCCUPATION	HOW WERE YOU REFERRED TO US?
EMPLOYER NAME	EMPLOYER ADDRESS

SPOUSE/GUARDIAN INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
EMPLOYER NAME	EMPLOYER ADDRESS		

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

PLEASE PROVIDE YOUR MEDICAL OR VISION INSURANCE CARDS FOR US TO COPY

	INSURANCE NAME	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO SUBSCRIBER	
1ST MEDICAL INSURANCE					
2ND MEDICAL INSURANCE					**VISION PLAN ID NUMBER**
VISION PLAN (OR 3RD INS.)					

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to AV EYE CARE (Drs. Opatowsky or Antebi) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware that there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare, the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

PATIENT OR GUARDIAN SIGNATURE	TODAY'S DATE

PCP/REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN NAME	DATE OF LAST VISIT
OPTOMETRIST NAME	**DATE OF LAST VISIT**

EYE HEALTH HISTORY

Do you wear glasses? YES NO	If yes, how often? ☐ All the time ☐ Reading ☐ Driving ☐ TV			
Do you wear contact lenses? YES NO	Type		Hours per day	
Have you had eye surgery? YES NO	If so, what year?	Right Eye	Left Eye	
What kind of surgery did you have?				
Describe any problems with your eyes				

Please check the box if you have had any of the following. ***CHECK THIS BOX IF NONE APPLY*** ☐

Blurred Vision – Distance ☐	Double Vision ☐	Headaches ☐	Retinal Disease ☐
Blurred Vision – Near ☐	Dry Eyes ☐	Itching Eyes ☐	Seeing Haloes ☐
Burning Eyes ☐	Eye Infection ☐	LASIK Surgery ☐	Seeing Flashes ☐
Cataracts ☐	Eye Injury ☐	Light Sensitivity ☐	Temporary Loss of Vision ☐
Poor Color Vision ☐	Eye Strain ☐	Loss of Vision ☐	Twitching Eyelids ☐
Crossed or Lazy Eyes ☐	Fainting Spells/Blackouts ☐	Macular Degeneration ☐	Watering Eyes ☐
Discharge from Eyes ☐	Floaters or Spots ☐	Poor Night Vision ☐	
Dizzy Spells ☐	Glaucoma ☐	Red Eyes ☐	

MEDICATIONS AND SUPPLEMENTS

List medications you are currently taking including eye drops.

ALLERGIES

List your allergies to medications or other substances

HEALTH HISTORY

Please check the box if you or a family member have had any of the following. ***CHECK THIS BOX IF NONE APPLY*** ☐

	YOU	FAMILY		YOU	FAMILY		YOU	FAMILY
AIDS/HIV	☐	☐	Emphysema	☐	☐	Pacemaker	☐	☐
Arthritis	☐	☐	Epilepsy	☐	☐	Rheumatic Fever	☐	☐
Artificial Heart Valve	☐	☐	Hay Fever	☐	☐	Skin Conditions	☐	☐
Artificial Joints	☐	☐	Heart Condition	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Hepatitis (Type___)	☐	☐	Thyroid Conditions	☐	☐
Bleeding	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Are you pregnant?	☐ YES	☐ NO
Chemical Dependency	☐	☐	Lupus	☐	☐	Do you use tobacco?	☐ YES	☐ NO
Diabetes	☐	☐	Migraines	☐	☐	Do you use alcohol?	☐ YES	☐ NO

REVIEW OF SYSTEMS

Do you currently have any of the following problems?	YES	NO	**If yes, please explain**
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (chest pains, irregular heart beat)	☐	☐	
Respiratory problems (shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary problems (pain or discomfort, blood in urine, prostate)	☐	☐	
Skin problems (rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (depression, anxiety)	☐	☐	