Patient Registration Information

(Please fill out completely. All information is confidential.)

Insurance Cards Copied Date:

LAST NAME	**FIRST NAME**	**MI**	
SSN	**DATE OF BIRTH**		
STREET			**APT.**
CITY	**STATE**	**ZIP CODE**	
EMPLOYER/NAME OF SCHOOL:		**WORK PHONE#:**	**HOME PHONE#:**
OCCUPATION:		**CELL PHONE#:**	
EMAIL ADDRESS			
SPOUSE'S NAME:	**SPOUSE'S DOB:**		

Insurance Information

Vision Insurance:	**Primary Medical Insurance:**
Subscriber's name:	**Subscriber's name:**
Subscriber's ID:	**Subscriber's ID:**
Subscriber's Group#:	**Subscriber's Group#:**
Subscriber's DOB:	**Subscriber's DOB:**

Assignment of Benefits - Financial Agreement

I hereby give authorization of insurance benefits to be made directly to Dr. Karen B. Murray for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services and materials rendered. If I fail to pay my bill as agreed, I will pay for all costs in enforcing or collecting any balance owed on my account, including reasonable attorney fees. I certify that the information is true and correct to the best of my knowledge.

Your Signature: **Date:**

Parent/Guardian (if a minor): **Date:**

Patient Eye History

Date of last eye exam:
By whom?
Have you ever tried contact lenses? ☐ **yes** ☐ **no**
Do you currently wear contact lenses? ☐ **yes** ☐ **no**
If so, what kind?
Solution used?
Replacement schedule: ☐ **2 weeks** ☐ **4 weeks** ☐ **annually**
Average wearing time per day:

If you wear bifocals, do the lines or head tilting bother you?
☐ **yes** ☐ **no**

If you wear contact lenses, are you satisfied with the vision and comfort? ☐ **yes** ☐ **no**

Family Medical/Eye History (Check all that apply)
Is there a family medical history of any of the following?
(Relationship)

☐ Blindness _____
☐ Lazy Eye _____
☐ Cataracts _____
☐ Macular Degeneration _____
☐ Corneal Problems _____
☐ Retinal Problems _____
☐ Glaucoma _____

☐ Diabetes

☐ High Blood Pressure

☐ Heart Disease

☐ I don't smoke ☐ Yes, I smoke per day
☐ I don't drink alcohol ☐ Yes, I drink per day

Have you ever been diagnosed or treated for the following?

☐ Cataracts ☐ Iritis/Uveitis
☐ Corneal Abrasion ☐ Lazy Eye
☐ Eye Infection ☐ Macular Degeneration
☐ Eye Injury ☐ Retinal Detachment
☐ Glaucoma ☐ Other Eye Disorders

Do you experience or have you ever experienced?

☐ Blurry Vision ☐ Flash of Light ☐ Sunlight Sensitivity
☐ Burning ☐ Floaters/spots ☐ Crossed eye/eye turn
☐ Tearing ☐ Grittiness ☐ Poor night vision
☐ Headaches ☐ Itchiness ☐ Uncomfortable glasses
☐ Double Vision ☐ Occasional dryness

Do you . . . (Check box if your answer is yes)

☐ Work at a computer?
☐ Think you might benefit from thinner, lighter lenses?
☐ Have interest in trying the latest contact lens design?
☐ Spend time outdoors? How much? hours/week
☐ Have prescription glasses
☐ Prefer not wear your glasses at times?
☐ Want information on Laser Vision Correction surgery?
☐ Have trouble with night driving?
☐ Have backup Rx glasses in case of emergencies?

Patient Medical History

Name of family physician:
City:
Date of last physical exam:

Current medications (Rx or OTC), including eye drops, vitamins, and birth control)

Allergies to medications (if any):

Have you ever been diagnosed or treated for the following:

☐ Allergies ☐ Heart Disease
☐ Asthma ☐ High Blood Pressure
☐ Arthritis ☐ Kidney
☐ Cancer ☐ Nerves
☐ Cholesterol ☐ Thyroid
☐ Diabetes ☐ Other -

I have had major surgeries in the past: ☐ yes ☐ no
If yes, please provide the approximate date and type of surgery:

Other hospitalizations: ☐ yes ☐ no

Review of Systems - if you **currently** have any of the following problems, please mark the appropriate box.

Systemic problems:
☐ Fever ☐ Weight loss ☐ Weight gain ☐ Night sweats ☐ None
Ear/Nose/Throat:
☐ Hearing Loss ☐ Sinus Trouble ☐ Hoarseness ☐ Vertigo ☐ None
Heart problems:
☐ Chest pain ☐ Irreg. heartbeat/palpitations ☐ Heart failure ☐ None
Respiratory problems:
☐ Wheezing ☐ Coughing ☐ Asthma/bronchitis ☐ Emphysema ☐ None
Gastrointestinal problems:
☐ Heartburn ☐ Abdominal pain ☐ Diarrhea ☐ Vomiting ☐ None
Urinary problems:
☐ Pain ☐ Blood in urine ☐Kidney stones ☐ Urinary infection ☐ None
Skin problems:
☐ Rashes ☐ Dryness ☐ Psoriasis ☐ Eczema ☐ None
Musculoskeletal:
☐ Joint/muscle pain ☐ Swelling ☐ Back trouble ☐Injury ☐ None
Neurological problems:
☐ Numbness ☐ Weakness ☐ Headaches ☐ Dizziness ☐ None
Psychiatric problems:
☐ Anxiety ☐ Depression ☐ Claustrophobia ☐ Other phobias ☐ None

Medical History reviewed by _____ **Karen Murray, O.D.**
Doctor's Signature