

# SQUINT OPTOMETRY PLLC

## REGISTRATION AND HEALTH HISTORY

NAME:		TODAY'S DATE:	
ADDRESS:		DOB:	
HOME PHONE:	CELL PHONE:	EMAIL:	
MALE/FEMALE:	MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
SSN:	DATE & LOCATION OF LAST EYE EXAM:		
EMPLOYER'S NAME/OCCUPATION:			

### OCULAR AND FAMILY HISTORY

**Check all that apply:**

**Self    Family Member?**

Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Drink Alcohol	<input type="checkbox"/>	
Drink Coffee	<input type="checkbox"/>	
Drooping Eyelid	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury or Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
LASIK	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Smoker	<input type="checkbox"/>	
Strabismus	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/> Please describe:

Are you nursing?  yes  no

Are you pregnant?  yes  no

Do you wear glasses?  yes  no

Do you wear contact lenses?  yes  no

**If yes, please check all that apply:**

- |                                     |                                     |                                     |                                        |                                      |
|-------------------------------------|-------------------------------------|-------------------------------------|----------------------------------------|--------------------------------------|
| <input type="checkbox"/> Soft       | <input type="checkbox"/> Toric      | <input type="checkbox"/> Monovision | <input type="checkbox"/> Extended Wear | <input type="checkbox"/> 2-week Lens |
| <input type="checkbox"/> Multifocal | <input type="checkbox"/> Daily Wear | <input type="checkbox"/> 1-Day Lens | <input type="checkbox"/> Monthly Lens  | <input type="checkbox"/> Rigid       |

**Brand Name:**

Current medications and vitamins:

How did you hear about us?

Reason for your visit:

# SQUINT OPTOMETRY PLLC

## PRIMARY INSURANCE INFORMATION

Insurance Name:	ID#
Policy Holder's Name:	Relationship to Patient:
Policy Holder's DOB:	Phone No.:

## SECONDARY INSURANCE INFORMATION (If Applicable)

Insurance Name:	ID#
Policy Holder's Name:	Relationship to Patient:
Policy Holder's DOB:	Phone No.:

## VISION INSURANCE INFORMATION

Vision Plan Name:	ID#
Policy Holder's Name:	Relationship to Patient:
Policy Holder's DOB:	Phone No.:

*I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers of Medicare and Medicaid Services or its intermediaries or carriers or to the billing agent of this physician, any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or the party who accepts assignment.*

Signature of Patient, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## HIPAA ACKNOWLEDGEMENT

I, \_\_\_\_\_, acknowledge that I have been provided with a copy of SQUINT OPTOMETRY, PLLC Privacy Notice and have been given an opportunity to read and ask questions about the notice.

Signature of Patient, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_