Alachua Family Eye Care - New Patient Registration

Date ____________________

Patient's Name ______________________________ **Mr. / Mrs. / Ms. / Miss / Dr.**

***Guardian/Guarantor (if applicable)** ______________________________

Address ______________________ **City** ______________ **State** ____ **Zip** ______

Patient's D.O.B. __________________ **E-Mail** ______________________

Primary phone: __________________ Home / Cell / Work / Other

Secondary phone: __________________ Home / Cell / Work / Other

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Who referred you to us? (Name) ______________________ (Please circle below)

Family Member Friend/Acquaintance Website Social Media Insurance Listing Physician Walk in

Please list household members that come to our office ______________________

Occupation ______________ **Employer** ______________ **City** ____________

Special Visual Demands (work or hobbies) ______________________

Primary Care Physician: ______________________

Please CIRCLE if PATIENT has (or ever had) any of the following:

MEDICAL CONDITIONS: Diabetes High Blood Pressure Stroke Thyroid dysfunction Migraines MS Lupus Rheumatoid Arthritis Cancer HIV

EYE CONDITIONS: Cataracts Glaucoma Macular degeneration Retina disease Cornea disease Lazy eye Dry eyes Eye allergies Eye injury Eye surgery Eye infection Vision loss

Medications: ______________________________

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Drug/Latex allergies? YES / NO - If yes, please list ______________________

Does PATIENT: **Wear glasses?** YES / NO **Wear contact lenses?** YES / NO / INTERESTED

Is PATIENT happy with current glasses? YES / NO **New glasses today?** YES / NO / UNSURE

Vision insurance? YES / NO **Company** ______________________

Insurance Guarantor = Self / Other (Name, Relation, DOB) ______________________

Medical insurance? YES / NO **Company** ______________________

Insurance Guarantor = Self / Other (Name, Relation, DOB) ______________________

I have read and understand the HIPAA privacy policy. SIGNATURE ______________________