PATIENT REGISTRATION

Last Name	First Name	Date of Birth	Age	Sex

Address	Vision or Medical Insurance Plans: (please check all that apply) ☐ Vision Service Plan ☐ Medical Eye Services ☐ Davis Vision ☐ Other:_____	☐ Medicare/Tricare For Life ☐ Tricare Prime ☐ Superior Vision ☐ Eye Med
City, State ZIP		
Home Phone	Patient's SSN	
Work Phone	Insured (Sponsor's) SSN	DOB:

Occupation	☐ Active Duty ☐ Retired	Emergency contact person / phone number

Email:

EYE HEALTH HISTORY

Please list any eye drops you are currently using:		
Date of last eye exam	Name of last eye doctor	Age of glasses

Do you wear contact lenses? ☐Yes → Which type? ☐ hard ☐ soft ☐ disposable ☐ No → Are you interested in contact lenses? ☐ yes ☐ no	Sports, hobbies, activities

Do you currently experience any of the following ocular symptoms? (Check all that apply)

- ☐ blurry vision
- ☐ glare at night
- ☐ halos around lights
- ☐ variable/ unstable vision
- ☐ dry eye
- ☐ itchy eye
- ☐ redeye
- ☐ burning sensation
- ☐ unusual growth on eyes or eyelids
- ☐ unusual discharge a
- ☐ eye pain or strain a
- ☐ double vision a
- ☐ headaches
- ☐ flashes of light
- ☐ floaters
- ☐ temporary loss of vision
- ☐ other _____

REVIEW OF SYSTEMS

Please indicate if you have any problems in the following areas, (check all that applies)

- ☐ Constitutional (weight gain/loss, chills)
- ☐ Ear, Nose, Mouth, Throat
- ☐ Musculoskeletal (muscles, joints)
- ☐ Genitourinary (genitals/kidney/bladder)
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Integumentary (Skin)
- ☐ Psychiatric
- ☐ Hematologic/Lymphatic
- ☐ Gastrointestinal
- ☐ Neurological
- ☐ Endocrine
- ☐ Allergic/immunologic

Please provide details for all boxes checked: _____

PAST MEDICAL / FAMILY / SOCIAL HISTORY

Please list all medications you take: _____

Please list all allergies to medications: _____

Please indicate any previous surgeries or hospitalizations: _____

Please indicate (circle all that applies) if you use: (Tobacco products / Alcohol / Illegal drugs / None)

Please indicate if you or a family member has any of the following conditions, (circle all that applies)

Eye disease	(self / family)	Asthma	(self /family)	Heart condition	(self /family)
Eye injury	(self /family)	Cancer	(self /family)	Migraines	(self /family)
Eye surgery	(self / family)	Diabetes	(self /family)	Thyroid condition	(self /family)
Lazy eye	(self /family)	High blood pressure	(self / family)	Other_____	(self /family)
Glaucoma	(self /family)				

Please provide details for all conditions circled: _____

LIFETIME PATIENT SIGNATURE

I hereby request that payment of authorized Medicare or other vision or medical insurance benefits be made directly to **Dr. Tammy Tran. O.D. a Professional Corporation** for any qualified services furnished by that doctor. I hereby authorize the above named doctors to release any medical information necessary to my insurance company to secure any payments. I hereby accept financial responsibility for rendered services that are not covered by my vision or medical insurance company.

PATIENT SIGNATURE _____ **DATE** _____