PATIENT REGISTRATION
TOPPINO EYECARE

PLEASE PRINT ***** FILL OUT COMPLETELY**

PATIENT: _____ **Date of Birth** _____
LAST NAME FIRST NAME MIDDLE INITIAL

ADDRESS: _____
STREET

_____
CITY STATE ZIP CODE

SS# _____ **PHONE**:_____ **CELL:**_____

SEX: (circle)⇒ **M** or **F** **Marital Status** (circle one) ⇒ **Single** **Married** **Divorced** **Widowed**

RACE: (circle)⇒ White Black-African Am. Asian Am. Indian-Alaskan Hispanic Native Hawaiian-other Declined-unknown

Ethnicity: (circle)⇒ Hispanic Non-Hispanic Declined-unknown **Language Preferred:**_____

Contact Preferred: (circle)⇒ Phone Mail E-Mail **Email:**_____

PATIENT'S EMPLOYER:_____ **WORK#**:_____

SPOUSE NAME:_____ **EMPLOYER**:_____ **WK#** _____

IF PATIENT IS A MINOR OR HAS A LEGAL CUSTODIAN, RESPONSIBLE ADULT IS:

NAME:_____ ADDRESS:_____

PHONE:_____ DOB: _____ SS#:_____

Name & Phone # for person to contact in emergency: (*not living with you)* _____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE :_____

Who does this policy belong to? (circle -SELF) or ⇒ Name:_____

Relationship_____**Their SS#**_____ **Date of Birth:** _____

NAME OF SECONDARY/ SUPPLEMENT INSURANCE: (if any) _____

Who does this policy belong to? (circle -SELF) or ⇒ Name:_____

Relationship_____ **Their SS#**_____ **Date of Birth:**_____

LIFETIME AUTHORIZATION MEDICARE/MEDIGAP/OTHER INSURANCES
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediates or carriers, any information needed for this or a related Medicare or other insurance claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare or other insurance for payment to me.

WE DO FILE CALIMS WITH MEDICARE AND CERTAIN MANAGED CARE PLANS. PATIENTS COVERED UNDER THOSE PLANS WILL BE RESPONSIBLE FOR PAYING ANY CO-PAY AND/OR DEDUCTIBLE AMOUNTS AT THE TIME OF SERVICE. ALL OTHERS MUST PAY FOR SERVICES IN FULL WHEN RENDERED, UNLESS PRIOR ARRANGEMENTS ARE MADE WITH THE INSURANCE COORDINATOR. I UNDERSTAND THAT ULTIMATELY I AM PERSONALLY RESPONSIBLE FOR MY ACCOUNT, INCLUDING NON-COVERED SERVICES. NOTE: IF MY ACCOUNT HAS TO BE TURNED OVER TO COLLECTIONS, I
UNDERSTAND THAT I WILL BE CHARGED THE CURRENT FLORIDA LEGAL INTEREST RATE PER MONTH UNTIL PAID. INFORMATION AVAILABLE AT FRONT DESK OR BILLING COORDINATOR.

A COMPLETE EXAM DOES NOT INCLUDE MEASUREMENTS AND/OR FITTING FOR CONTACT LENSES.
REFRACTIONS ARE A NON-COVERED SERVICE BY MEDICARE AND MOST OTHER INSURANCES, BUT MAY BE PART OF AN EXAM AND DUE AT THE TIME OF SERVICE.

SIGNATURE _____ **DATE** _____

Relationship if signed by someone other than patient_____
How did you hear about us? _____

PATIENT HISTORY QUESTIONNAIRE

Name and Phone Number of Primary Care Physician:

_____

Last Seen: _____

PAST MEDICAL HISTORY:
□ Diabetes □ Hypertension □ Hyperthyroidism □ Hypothyroidism

Other: _____

Allergies to Medications?⇒ ⇒ □ YES---or ---□ No -------if Yes, please list them: _____

_____

List any/all eye surgeries (incl. laser)& approx. dates; List any eye conditions/diseases:

_____

_____

Please list all major operations or hospital admissions and the approx. dates:

_____

_____

Please list all eye drops that you are currently taking:
Name/strength Which eye How often? Reason

_____

_____

_____

Please list all other medications you are currently taking: *[or attach list]****
Name/strength How often? Reason

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY / REVIEW OF SYSTEMS

Do **YOU** currently have problems in the following areas? If "YES", please provide information.

	YES	NO	EXPLANATION
EYES glaucoma, cataract, retinal disease,etc			
GENERAL/CONSTITUTIONAL (fever, weight loss/gain , fatigue etc)			
EARS, NOSE THROAT (sinus, ear infection, chronic cough, dry mouth, etc)			
CARDIOVASCULAR heart, circulation			
RESPIRATORY(asthma, emphysema)			
GASTROINTESTINAL ulcers etc			
GENITAL, KIDNEY, BLADDER			
MUSCLE, BONES, JOINTS (arthritis etc)			
SKIN (skin cancer, etc)			
NEUROLOGICAL (stroke,seizures)			
PSYCHIATRIC (anxiety,depression,insomnia)			
ENDOCRINE (diabetes, thyroid, etc)			
BLOOD/LYMPH Cholesterol, anemia			
ALLERGIC/IMMUNOLOGIC(hayfever, Lupus, Sjogrens, etc)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO		DISEASE	YES	NO	
Blindness				Thyroid Dis.			
Glaucoma				Arthritis			
Retina detachment				Diabetes			
Cataract				Hypertension			
Macular Degenerat.				Stroke			
Heart Disease				Cancer			

SOCIAL HISTORY: marital status (circle)

MARRIED SINGLE SEPARATED DIVORCED WIDOWED

CURRENT OR PAST OCCUPATION_____RETIRED **Yes/ No**

	YES	NO	EXPLANATION
Do you drink alcohol?			Frequency?
Do you use tobacco?			Packs per Day? Year you quit
Do you use any type of street drug?			
Have you ever had a blood transfusion?			
Do you drive?			
Do you wear contact lenses?			Hours per day?
Do you sleep with contact lenses?			
Do you wear CL in water?			Shower/ Pool/ Lake/ Ocean

OCULAR SURVEY:
Do **YOU** currently experience **ANY** of the following?

	YES	NO	EXPLANATION
Itchy Eyes			
Gritty Eyes			
Watery Eyes			
Intermittent blurred vision			
Feel like something in eye			
Floaters/Spots/Strings			
See Geometric Shapes			
Light Sensitivity			
Haloes around lights			
Glare from lights			
Double Vision			
Flashing Lights			
Difficulty adjusting to Glasses			
Difficulty using eye drops			
Difficulty night driving			
Difficulty seeing street signs			
Other			