PATIENT REGISTRATION

Date____________

Name____**Date of Birth**___________**Age**____

Address____________________________**City**________________________**State**_____**Zip**________

Hm Phone(   )_____________**Wk Phone(   )**____________**Social Security #**__________________

Employer_________________________________**Occupation**________________________________

Sex Male___ **Female**___   **Married**___ **Single**___ **Divorced**___**Email**________________________

Vision Insurance_______________**Name/DOB Policy Holder**________________________________

Last Eye Exam___________________________**By Whom?**______________________________

Reason for exam: GLASSES_____**CONTACTS**_____**EYE INJURY**_____**OTHER**________________

Have you ever worn CONTACT Lenses?__________**Last time worn**__________**Type**____________

Current MEDICATIONS____

Do you have:

__**Allergies**
__**Diabetes**
__**High Blood Pressure**
__**Glaucoma**
__**Cancer**
__**Asthma**
__**Heart Disease**
__**Respiratory Problems**
__**Eye Disease**
__**Other**

Have you ever had an Eye Injury or Eye Surgery?____

DO YOU WANT YOUR EYES TO BE DILATED? YES NO (Required for Diabetic Exam)

MAY WE PERFORM RETINAL PHOTOGRAPHY? YES NO (No Dilation Required)
Retinal Photography is recommended **yearly** to screen for diabetes, glaucoma, macular degeneration, and other eye conditions. Your photos are viewed during each exam to detect any changes.

I acknowledge that I have read/received a copy of the Notice of Privacy Practices.
I authorize the release of any medical information necessary for the procession of insurance claims.
I hereby assign major medical benefits to which I am entitled to Dr. John Deapen.
I understand that I will be responsible for any and all charges not covered by my insurance and associated collection fees.
I understand there are no refunds on optical goods or services.

Signature **Date**