Patient Registration:

Name: ____ Nickname: ______________

Date of Birth: ____________________ Age: _______ Social Security #: __________________________

Home Phone: ____

Cell Phone Number: ____ Ok to text: YES or NO

Work Phone Number: ____

Address: ____

City: ____ State: __________ Zip: ______________

Email Address: ____

Occupation and Place of Employment: ____

Primary Care Physician: ____

Language, Race, Ethnicity: ____

How did you hear about us? ____

Insurance Information: Do you have vision insurance? YES or NO

Primary Member Name: ______________________________________ Date of Birth: _________________

Social Security #: ______________________________ Insurance ID #: ______________________________

Insurance Name: _________________________________ Relationship to Insured: _____________________

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Miss-Lou Eye Care and Bridget A. Milliken, O.D. for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. By signing this form, I consent to Miss-Lou Eye Care's use and disclosure of protected health information for treatment, payment, and health care operations. I have the right to revoke this Consent, in writing, signed by me. I acknowledge I have read Miss-Lou Eye Care's Notice of Privacy Practices.

Signature: ____Date: ________________*

Please turn this form over and complete *

Patient Name: ____ Date: _________________

A copy of this information and Notice of Privacy Practices is made available on request.

Medical History:

Are you allergic to any medications? ☐ Yes ☐ No ; If you answered yes, please list: ________________
____

List any medications that you take:
____
____

Ocular history: Circle any of the following that you have had: Crossed eyes Lazy eyes Drooping Lids Prominent eyes Glaucoma Retinal disease Cataracts Eye Infections

Have you ever had any eye injuries or surgeries? ☐ Yes ☐ No

Please explain if you marked any of the above: ____

Family History: Circle all of the following that you are aware of in your family:

Blindness Cataracts Crossed Eyes Diabetes Glaucoma Macular Degeneration Retinal Disease Heart Disease High Blood Pressure Thyroid Disease

If you circled any of the above, please explain relationship:

Social History:

Do you wear glasses? ☐ Yes ☐ No Do you wear contacts? ? ☐ Yes ☐ No

Date of last eye exam ?____

Do you use tobacco products? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No Height ____________ Weight _____________

Review of Systems:

Constitutional	Yes	**Ears, Nose, Mouth, Throat**	Yes
Fever, Weight Loss/Gain	☐	**Allergies, Hay Fever**	☐
Skin Problems	☐	Sinus Congestion	☐
Neurological		Runny Nose/Nasal drip	☐
Headaches	☐	Dry Throat/Mouth	☐
Migraines	☐	**Respiratory**	
Seizures	☐	Asthma	☐
Eyes		Chronic Bronchitis	☐
Loss of Vision	☐	Emphysema	☐
Blurred Vision	☐	**Vascular/ Cardiovascular**	
Distorted Vision/Halos	☐	Diabetes	☐
Double Vision	☐	Heart Pain	☐
Dryness/Watering	☐	Vascular Disease	☐
Sandy/ Gritty Feeling	☐	High Blood Pressure	☐
Discharge/Redness	☐	**Gastrointestinal**	
Itching/ Burning	☐	Diarrhea/Constipation	☐
Foreign Body Sensation	☐	**Genitourinary**	
Glare/ Light Sensitivity	☐	Kidney/ Bladder	☐
Eye Pain or Soreness	☐	**Bones/Joints/Muscles**	
Infections of Eye or Lid	☐	Rheumatoid Arthritis	☐
Flash/Floaters in Vision	☐	Muscle/ Joint Pain	☐
Tired Eyes	☐	**Lymphatic/Hematologic**	
Endocrine Thyroid/Other Gland	☐	Anemia/Bleeding	☐
Cancer (type: _______________)	☐	**Psychiatric**	☐

Reason for today's visit?
____