

PATIENT REGISTRATION

Last Name	First Name	Date of Birth	Age	Sex
Address		Vision or Medical Insurance Plans: <input type="checkbox"/> Vision Service Plan <input type="checkbox"/> Medicare/Tricare For Life <input type="checkbox"/> Medical Eye Services <input type="checkbox"/> Tricare Prime (please check all that apply) <input type="checkbox"/> Davis Vision <input type="checkbox"/> Superior Vision <input type="checkbox"/> Other: _____ <input type="checkbox"/> Eye Med		
City, State ZIP		Patient's SSN		
Home Phone		Insured (Sponsor's) SSN		
Work Phone		DOB:		
Occupation		<input type="checkbox"/> Active Duty <input type="checkbox"/> Retired Emergency contact person / phone number		

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? <input type="checkbox"/> Yes → Which type? <input type="checkbox"/> hard <input type="checkbox"/> soft <input type="checkbox"/> disposable <input type="checkbox"/> No → Are you interested in contact lenses? <input type="checkbox"/> yes <input type="checkbox"/> no		Sports, hobbies, activities

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

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> blurry vision | <input type="checkbox"/> itchy eye | <input type="checkbox"/> unusual discharge a | <input type="checkbox"/> floaters |
| <input type="checkbox"/> glare at night | <input type="checkbox"/> redevye | <input type="checkbox"/> eye pain or strain a | <input type="checkbox"/> temporary loss of vision |
| <input type="checkbox"/> halos around lights | <input type="checkbox"/> burning sensation | <input type="checkbox"/> double vision a | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> variable/ unstable vision | <input type="checkbox"/> unusual growth on eyes | <input type="checkbox"/> headaches | |
| <input type="checkbox"/> dry eye | <input type="checkbox"/> or eyelids | <input type="checkbox"/> flashes of light | |

REVIEW OF SYSTEMS

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

- | | | |
|--|--|---|
| <input type="checkbox"/> Constitutional (weight gain/loss, chills) | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Ear, Nose, Mouth, Throat | <input type="checkbox"/> Integumentary (Skin) | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Musculoskeletal (muscles, joints) | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Genitourinary (genitals/kidney/bladder) | <input type="checkbox"/> Hematologic/Lymphatic | <input type="checkbox"/> Allergic/immunologic |
| <input type="checkbox"/> Cardiovascular | | |

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 _____