AZALEA
– EYE CARE –

STEP 1 PATIENT REGISTRATION

Date: _____

Mr. Mrs. Miss. Ms. Dr. Last: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____ Sex: ☐ Male ☐ Female Social Security #: _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic Height: _____ Weight: _____

Street Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Preferred method of contact: ☐ Call ☐ Text ☐ Email

Employer/Occupation: _____/_____ School/Grade: _____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse: _____

List name(s) & age(s) of dependent children: _____

What is the major reason for your visit? _____

Are you currently wearing eyeglasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No

If wearing contact lenses, what would you change about them? _____

Do you work on a computer? ☐ Yes ☐ No How many hours per day? _____

When & where was your last eye exam? _____ Performed by Dr. _____

I authorize the release of any medical or other information necessary to process insurance claims.

I authorize payment of vision/medical benefits to the physician for services rendered.

X_____

Signature of Patient (Or Legal Guardian if Minor)

STEP 2 MEDICAL HISTORY

MEDICATIONS

- ☐ None
- _____
- _____
- _____
- _____
- _____

MEDICATION ALLERGIES: (☐ None)

- _____

PRIMARY CARE PHYSICIAN

Name: _____
(Last) (First)

Address: _____

_____

Phone: _____

Fax: _____

PAST PERSONAL HISTORY

Please describe all serious illnesses, injuries, and surgeries: _____

_____

_____