NORTHWEST EYE SPECIALISTS, PLLC
REGISTRATION FORM

ORACLE EYE
PHYSICIANS & SURGEONS

Today's date:	**Primary Care Physician:**

PATIENT INFORMATION

Patient's last name:	**First:**	**Middle:**	❑ **Mr.** ❑ **Mrs.**	❑ **Miss** ❑ **Ms.**	**Marital status (circle one)** Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Race:	Ethnicity:	**Language:**	**SSN:**	**Nickname:**

Street Address:	**Cell phone:** ( )	**Home phone:** ( )

P.O. Box:	**City:**	**State:**	**ZIP Code:**

Occupation:	Employer:	Employer phone: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑Website ❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )

Relationship to patient:	**Policy #:**

Name of primary insurance:	**Subscriber's name:**	**Group #:**

Name of secondary insurance (if applicable)	**Subscriber's name:**	**Group #:**	**Policy #:**

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone: ( )	Cell Phone ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize Northwest Eye Specialists, P.L.L.C. dba Oracle Eye Physicians and Surgeons to release to the Social Security Administration & the Center for Medicare & Medicaid Services or its intermediaries or carriers any information needed for any Medicare or private insurance claim. I permit a copy of this authorization to be used in place of the original & request payment of insurance benefits be paid to Northwest Eye Specialists, P.L.L.C. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Patient or Guardian signature ***Date***

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Today's Date:_____

HEALTH HISTORY & REVIEW OF SYSTEMS

Legal Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Place of Birth: _____

Primary Care Physician:_____

Allergic to: None known Latex IV contrast dye Iodine Eggs Environmental

Medication allergies/Reaction:_____

List surgeries/Year: _____

Mobility status: Ambulatory Wheelchair Walker Unable to bear weight

Do you wear contact lenses? NO YES If yes, type/brand: _____

Please *circle* any condition below with which you have been diagnosed- add comments as necessary

Eyes:	no problems	glaucoma injury	cataracts	macular degeneration
Cardiovascular:	no problems	high blood pressure cardiac murmur pacemaker stent (If so, current cardiologist:_____)	heart attack atrial fibrillation	coronary artery disease congestive heart failure
Respiratory:	no problems lung cancer	asthma home oxygen use	emphysema/COPD	tuberculosis
Endocrine:	no problems	diabetes	thyroid disease	
Gastrointestinal:	no problems	hepatitis A/B/C/D reflux disease	liver disease colon cancer	ulcers
Genitourinary:	no problems	kidney disease prostate enlargement	dialysis prostate cancer	urinary tract infections kidney transplant
Neurologic:	no problems	stroke multiple sclerosis	seizures Alzheimer's	Parkinson's disease psychiatric (list)
Heme/Immune:	no problems	anemia bleeding disorder Other cancers (list)	leukemia lupus	lymphoma HIV/AIDS
Musculoskeletal:	no problems	rheumatoid arthritis	osteoarthritis	osteoporosis
Dermatologic:	no problems	psoriasis	eczema	rosacea
Other: _____			MRSA	

Please continue on the other side of this page…

Please *circle* any problem below which you have had *recently*

Eyes:	blurry vision, double vision, distorted vision, eye pain	Other:_____
Ears/Nose/Throat:	ear pain, stuffy nose, sore throat, dry mouth	Other:_____
Cardiovascular:	chest pain, palpitations	Other:_____
Respiratory:	shortness of breath, cough	Other:_____
Endocrine:	fatigue, hair loss	Other:_____
Gastrointestinal:	abdominal pain, diarrhea, constipation, blood in stool	Other:_____
Genitourinary:	painful urination, difficulty urinating, blood in urine	Other:_____
Neurologic:	headache, weakness, numbness, imbalance	Other:_____
Heme/Immune:	easy bruising, nosebleeds	Other:_____
Musculoskeletal:	joint pains, poor mobility	Other:_____
Dermatologic:	rash, sores	Other:_____

FAMILY HISTORY- Please tell us which of your blood relatives have/had the following problems

Diabetes: _____ Heart disease: _____ High blood pressure: _____ Stroke: _____

Glaucoma: _____ Macular Degeneration: _____ Cancer (type): _____

SOCIAL HISTORY- Please tell us a bit about yourself

Occupation: _____

Hobbies/Interests: _____

Marital Status: Single Married Divorced Widowed

Emergency Contact: _____ Phone#: _____

Do you exercise? NO YES- type and frequency: _____

Do you drink alcohol? NO YES- type and frequency: _____

Do you smoke tobacco? NO YES- how much? _____ Age started: _____ Age quit: _____

Recreational drug use? NO YES- type and frequency: _____

Do you drive? NO YES

Please tell us who referred you to our practice: _____

_____ _____

Patient Signature **Date**

_____ _____

Signature of person other than patient completing this form **Date**

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MEDICATION LIST

Date Reviewed Tech Dr

_____ _____ _____

Patient Name _____ _____ _____ _____

_____ _____ _____

Date _____

Please list all medications you are presently taking.

Name of medication	Dose	How often taken

☐ I am not presently taking any medications.

_____

Patient Signature