If the patient is new, how did you hear of us: **REGISTRATION FOR ADULT PATIENTS**

PATIENT'S FIRST NAME, MIDDLE INITIAL AND LAST NAME	BIRTHDATE	SOCIAL SECURITY #

PATIENT'S GENDER AT BIRTH **If now identifies different than at birth, please specify:**

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language.

RACE	ETHNICITY	LANGUAGE PREFERENCE:

FULL STREET ADDRESS WHERE PATIENT LIVES (MUST INCLUDE STREET, CITY, STATE AND ZIP CODE)

MOBILE PHONE #	HOME PHONE #	EMAIL ADDRESS	Would you like to communicate with the office via email? ☐ Yes ☐ No
( )	( )		
Can you we send you appointment reminders via text message? ☐ Yes ☐ No	OTHER PHONE NUMBER ( )	ALTERNATE PHONE IS FOR □ PATIENT'S WORK □ FAMILY/OTHER:	

FAMILY DOCTOR/INTERNIST NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER
REFERRING DOCTOR'S NAME (IF DIFFERENT)	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER
OPTOMETRIST/OPHTHALMOLOGIST'S NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY/FRIENDS

To make it easier to discuss medical care about you with those that help you with care, we ask that you complete this form.
It is NOT necessary for you to give us permission to provide medical information to your other doctors. Example of who needs permission for us to talk to would be spouses/partners, children, parents, aunts/uncles, siblings, friends, neighbors, etc. I AUTHORIZE:

PERSON'S NAME:_______________________________________**DOB:**___________ **RELATIONSHIP:**___________ **PHONE #:**_____________________

PERSON'S NAME:_______________________________________**DOB:**___________ **RELATIONSHIP:**___________ **PHONE #:**_____________________

PERSON'S NAME:_______________________________________**DOB:**___________ **RELATIONSHIP:**___________ **PHONE #:**_____________________

PERSON'S NAME:_______________________________________**DOB:**___________ **RELATIONSHIP:**___________ **PHONE #:**_____________________

I understand that Children's Eye Care (CEC) does NOT participate with VISION insurance. Visits will be billed to the medical plan.

CEC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to CEC for reimbursement for services rendered, and (2) any health care provider for continued patient care. CEC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statue or regulation. A copy of this authorization may be used in place of the original. I authorize that my protected health information (also known as PHI) may be used or disclosed with the above-mentioned people. I understand that I have the right to be aware of all PHI that will be disclosed to these people. I understand that Children's Eye Care will not condition any aspect of my treatment or payment I understand that I am under no obligation to sign this Authorization. I understand that this Authorization may be revoked in writing at any time by my signing the revocation section below and returning it to Children's Eye Care unless: they have previously acted in reliance on this Authorization. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to Children's Eye Care to use or disclose PHI in accordance to the terms of the Authorization.
Financial Agreement: I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to CEC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CEC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Also, I agree to reimburse CEC the fees of any collection agency , which may be based on a percentage at a maximum of 25% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

SIGNATURE: ____ DATE:___________

PATIENT'S PRINTED NAME: ____

GUARDIAN INFORMATION IF ADULT PATIENT IS DEVELOPMENTALLY DELAYED

PARENT/GUARDIAN'S LAST NAME	FIRST NAME	CHECK ONE	BIRTHDATE	SOCIAL SECURITY #
		□Biological Parent □ Adopted Parent □ Step-Parent □Foster Parent □ Legal Guardian		
PARENT/GUARDIAN'S LAST NAME	**FIRST NAME**	**CHECK ONE**	**BIRTHDATE**	**SOCIAL SECURITY #**
		□Biological Parent □ Adopted Parent □ Step-Parent □Foster Parent □ Legal Guardian		

PATIENT'S NAME _____ DATE_____

If you wear eyeglasses, how old were you when you started wearing them?_____ How old is your current prescription?_____

If you wear contacts, how old is the prescription?_____ How many hours per day do you wear them?_____

If you have been told to do eye exercises, describe the excercises_____
_____
_____
_____

What is the approximate date of your last dilated eye exam?_____ Who did the exam?_____

REVIEW OF SYSTEMS - PLEASE CHECK EITHER YES OR NO * DO NOT LEAVE ANY UNANSWERED

HAVE YOU RECENTLY HAD: A fever ☐ YES ☐ NO Unintentional weight loss ☐ YES ☐ NO

DO YOU? Smoke cigarettes (including vaping) ☐ YES ☐ NO Use recreational drugs ☐ YES ☐ NO Abuse alcohol ☐ YES ☐ NO

YES NO
☐ ☐ Do you have double vision: if yes, when did it begin? _____

If you get double-vision, check all that apply
☐ notice it when looking at far distances (driving, watching tv, playing sports, etc)
☐ notice it when looking at near ranges (reading, using computer, doing fine handiwork like knitting, etc.)
☐ notice when looking a far and near ranges
☐ close your eye for comfort. If yes, which eye: ☐ RIGHT ☐ LEFT

If you get double vision, do you feel that it's (choose one): ☐ Improving ☐ Worsening ☐ No change

YES NO
☐ ☐ If you get double vision, do you have prism(s) in your glasses?
☐ ☐ Do you have distorted vision? If yes, which eye: ☐ RIGHT ☐ LEFT
☐ ☐ Do you have eye strain?
☐ ☐ Do you have misaligned eyes but no double vision?
☐ ☐ Did you have eye misalignment in childhood?
☐ ☐ Have you previously had eye muscle surgery? If yes, please be certain to document surgery in previous eye surgery area below

YES	NO	Have you ever been told you have?	YES	NO	Does/did any blood family member have?
☐	☐	Lazy eye/amblyopia (since childhood)	☐	☐	Lazy eye/amblyopia (since childhood)
☐	☐	Corneal disease	☐	☐	CorneaL disease
☐	☐	Diabetic eye disease	☐	☐	Diabetic eye disease
☐	☐	Glaucoma	☐	☐	Glaucoma
☐	☐	Retinal detachment/disease	☐	☐	Retinal disease
☐	☐	other_____	☐	☐	Other_____

Have you previously had cataract surgery or any eye surgeries or injuries (what, when) _____
_____
_____
_____

YES	NO	Have you ever been told you have?				YES	NO	Does/did any blood family member have?
☐	☐	Cancer	☐	☐	Kidney disease	☐	☐	Cancer
☐	☐	Diabetes - adult onset	☐	☐	Lung breathing disease	☐	☐	Diabetes - adult onset
☐	☐	Diabetes - childhood onset	☐	☐	Lupus or Multiple Sclerosis	☐	☐	Diabetes - childhood onset
☐	☐	Graves/Thyroid disease	☐	☐	Psychiatric disorder	☐	☐	Graves/Thyroid disease
☐	☐	Heart disease	☐	☐	Parkinson's disease	☐	☐	Heart disease
☐	☐	High blood pressure	☐	☐	Renal failure	☐	☐	High blood pressure
☐	☐	HIV/Aids	☐	☐	Rheumatoid arthritis	☐	☐	Lupus or multiple sclerosis
☐	☐	Problems with anesthesia	☐	☐	Skin disease	☐	☐	Parkinson's disease
☐	☐	Malignant hyperthermia	☐	☐	Sleep apnea and use of CPAP			
☐	☐	To take antiobiotics prior to dental work or surgery?						

☐ ☐ Other_____

How tall are you?:_____ What is your approximate weight: _____

Have you had any health-related surgeries or injuries? If not what was the issue/surgery and when did this occur?_____
_____
_____
_____

PATIENT'S NAME _____ DATE_____

Are you allergic to latex? ☐ YES ☐ NO

PLEASE LIST ANY ALLERGIES TO MEDICATIONS

PLEASE LIST THE MEDICATIONS (INCLUDING OVER THE COUNTER) YOU TAKE

Medication Name; Dosage & use (if known)	Reason Taking Med	FOR STAFF USE (Date & Initial)	(Date & Initial)
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C
		☐ Reviewed – Added ☐ Reviewed – D/C	☐ Reviewed –Added ☐ Reviewed – D/C