PATIENT REGISTRATION FORM
LANDES EYE ASSOCIATES

Date:____ /____ /____

PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____

I prefer to be called:_____ SSN:_____

Date of birth:____ /____ /____ Age:____ Sex:____ ____single ____married ____widowed

Home Address:_____ City/State:_____ Zip:_____

Home phone:_____ Cell:_____ Work:_____

My preferred phone:_____ Is it ok to leave a detailed message on your voicemail?_____

Email:_____ Is it ok to email you?_____

CONTACTS

Emergency name and relationship:_____ Phone:_____

Spouse name:_____ Phone:_____

Power of attorney:_____ Phone:_____

INSURANCE

Primary Medical Insurance:_____ Policy Holder:_____

Secondary Medical Insurance:_____ Policy Holder:_____

Vision Insurance:_____ Policy Holder:_____

DOCTORS and PHARMACY

Referred by:_____ Phone:_____

Primary Care Doctor:_____ Phone:_____

Preferred pharmacy:_____ Phone:_____

Medical Conditions – Please list all of your medical conditions.

_____
_____
_____
_____

If you have Diabetes, how many years:_____ Hgb A1C:_____

Past Surgeries – Please list your surgeries/procedures and the year if known.

_____
_____
_____
_____

Eye History – Please list all of your eye conditions including any surgeries, laser procedures, or treatments.

_____
_____
_____

Family History – Please list any medical conditions in your family, and please include any eye problems in your family such as blindness, glaucoma, and macular degeneration.

_____
_____
_____

Allergies – Please list all medication allergies and include reaction if known. If none, check this box:_____

_____
_____
_____

Social History

Alcohol:_____No _____Yes Smoking:_____No _____Yes _____Former Drug use:_____No _____Yes
Driving status:_____drives during day _____drives during night _____I no longer drive
Occupation/Place of work:_____

Review of Systems – Please circle if any of these complaints or conditions apply to you.

EYES
Previous surgery
Contact lens
Pain
Double vision
Glaucoma
Cataracts
Macular degeneration
Dry eyes
Flashes or floaters
Tearing
Loss of vision
Previous injury

EAR, NOSE, THROAT
Hard of hearing
Ringing in ears
Vertigo
Dry mouth
Tooth pain

CARDIOVASCULAR
Chest pain
Dizziness
Fainting
Shortness of breath
Irregular heart beat
Difficulty lying flat

CONSTITUTIONAL
Fatigue/weakness
Fever
Weight gain/loss
Sweats
Recent illness

RESPIRATORY
Cough
Congestion
Wheezing
Asthma
Snoring

GASTROINTESTINAL
Heartburn
Nausea/vomiting
Jaundice/hepatitis
Diarrhea/constipation

GENITO-URINARY
Pain/difficulty
Blood in urine
History of kidney stones
History of STD's
History of enlarged prostate

PSYCHIATRIC
Anxiety/depression
Mood swings
Difficulty sleeping
Memory problems

ENDOCRINE
Increased thirst
Increased hunger
Increased urination
Increased sweating
Fingernail changes
Thyroid abnormalities

BLOOD/LYMPHATIC
Easy bruising
Gums bleed easily
Prolonged bleeding
Heavy aspirin or blood thinner use
Blood clots
Swollen nodes

MUSCULOSKELETAL
Stiffness
Arthritis
Joint pain/swelling

SKIN
Rash/sores
Lesions
Hives/eczema
History of skin cancer

NEUROLOGICAL
Seizures
Weakness/paralysis
Numbness
Tremors
Headaches
Migraines

IMMUNOLOGIC
Hives
Itching
Runny nose
Sinus pressure

If none, check this box: _____

By signing this, I agree that the information I am providing is accurate and complete as possible.

Signature: _____ Date:_____