| Patient Registration Form | | | | | | | |
|---|--------------|----------|---|----------------|-----|--|--|
| Last Name | First Name | Initial | Gender F M | Date of Birth | SSN | | |
| Address Street | | Occupa | ation/emplo | yer/School | | | |
| City State/Zip | | | | | | | |
| Home Phone: Work Phone: | | Yellow I | How did you hear about our office? Yellow Pages □ Internet □ Insurance □ | | | | |
| Cell: Email: | | | Front Sign Walk-by Referred by Friends/Family: list Other: | | | | |
| Insurance and Payment Information: | | | | | | | |
| Responsible party | | | | | | | |
| Vision Insurance | | | | ID number | | | |
| Health Insurance | | | | | | | |
| I here by authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am responsible for the co-pay and all fees not covered by my insurance. | | | | | | | |
| Signature: | | | | Date: | | | |
| Notice of Privacy Practices: | | | | | | | |
| The information you provided here, and any information we collect during the examination, are confidential. We will use it only for the purpose of managing your condition, obtaining insurance payment and contacting you. A copy of The Notice of Privacy Practices is available for you to take. If you have any concerns or questions, please ask. | | | | | | | |
| I acknowledge that I have read and understood the above. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the notice of privacy practices from Dr. Mo. | | | | | | | |
| Signature: | | | | Date: | | | |
| Glasses and Contact Lens information: | | | | | | | |
| Do you wear glasses? Yes No Do you wear contact lenses? Yes No Type of contact lenses: []rigid [] soft []extended wear []daily wear Any complications from wearing contacts? | | | | | | | |
| Are you interested in getting contacts here? Yes No If so, please ask our staff to explain our contact lens service policy. | | | | | | | |
| Contact Lens Wearer Acknowledgement: Contact lenses are classified as medical devices by the FDA and have the potential to harm your eyes and/or result in complete permanent vision loss. Do not sleep in your contact lenses unless instructed to do so by your doctor. Do not swim in your contacts. Do not wear your contacts if the contacts are torn or damaged. Do not wear your contacts if your eyes are irritated. | | | | | | | |
| I have read and understood the above. I have received instruction on the care and use of my contact lenses. I understand that I must return to the doctor for follow-up appointments when required by my doctor. I understand that some contact lens problems do not result in discomfort and can only be detected with an exam. I have been informed of the necessity for yearly examinations to monitor my eye health and renew my prescription. It is my understanding that non-compliance with my doctor's instruction, improper use and care of contact lenses can cause irritation, infections, corneal injury and complete permanent vision loss. I may not hold the doctor, the dispenser, or the contact lens manufacturer responsible for such damages. | | | | | | | |
| I have read and agree to the office policy on contact lens services. | | | | | | | |
| Patient's or Guardian' | s Signature: | | | Date: | | | |

Patient Registration Form

| Do you drive? | Social History This information is k | ept strictly confidential. If you do | not wish to give | a written response, please discuss with the doctor. | | | | | |
|--|--|--------------------------------------|--|---|--|--|--|--|--|
| Does any of the following apply to your Please circle. []Smoke | | If yes, do you have vis | ual difficulty v | when driving? □ no □ yes if yes, please | | | | | |
| Review of Systems Do you currently, or have your ever had any problems in the following areas: Please check and explain. SYSTEM VASCULAR/CARDIOVASCULAR [Diabetes IDlabetes IDlabetes | | | | | | | | | |
| Review of Systems Do you currently, or have your ever had any problems in the following areas: Please check and explain. SYSTEM CONSTITUTIONAL []Fever, Weight Loss/Gain INTEGUMENTARY (SKIN) []Heart Pain []Vascular Disease []Alone GENITOURINARY []Genitals/Ridiney/Bladder []Headaches []Migraines []Betzems []Headaches []Migraines []Betzems []Betzems []Headaches []Migraines []Betzens []Betzens []Boltzures []Boltzures []Boltzures []Boltzures []Boltzures []Boltzures []Post-Nasal Drip []Chronic Cough []Dry Throat/Mouth []Dry Throat/Mouth []Blurged Problems []Blurged Vision []Blurring []Burning [| | | | | | | | | |
| Do you currently, or have your ever had any problems in the following areas: Please check and explain. SySTEM | □ I would prefer to discuss my Social history information directly with my doctor. | | | | | | | | |
| Do you currently, or have your ever had any problems in the following areas: Please check and explain. SYSTEM | Pavious of Systems | | | | | | | | |
| SYSTEM CONSTITUTIONAL []Fever, Weight Loss/Gain INTEGUMENTARY (SKIN) []Eczema []Acne []Head Fan []Acne []Head Fan []Acne []Head Fan []Acne []Head Aches []Head Aches []Head Aches []Kidney failure []Kidney failure []Runny Nose []Rental Kidney Failure []Chronic Cough []Dronined Worth Multicle Problems []Chronic Bronchitis []Chronic Bronchitis []Emphysema []Chronic Bronchitis []Diarhea []Chronic Bronchitis []Bipolar []Diarhea []Chronic Bronchitis []Bipolar []Diarhea []Chronic Bronchitis []Bipolar []Diarhea []Chronic Bronchitis []Eve surgery []Eye injury or trauma []Eye infections []Bipolar []B | | | | | | | | | |
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| | = = | GENITOURINARY | | 1 = = | | | | | |
| Migraines BONES JOINTS/ MUSCLES Sendors | | []Genitals/Kidney/Bladder | | | | | | | |
| Seizures Carrest Car | []Headaches | | | | | | | | |
| EARS, NOSE, MOUTH, THROAT Sinus Congestion Si | | | | 1 | | | | | |
| Sinus Congestion Runny Nose LYMPHATIC / HEMATOLOGIC Foreign Body Sensation Foreign Bod | | | | | | | | | |
| Runny Nose Post-Nasal Drip All Anemia | , | 1 | | 1 | | | | | |
| | , | | | | | | | | |
| Chronic Cough Bleeding Problems Chronic Cough Dry Throat/Mouth ALLERGIC / IMMUNOLOGIC Depression Chronic Bronchitis Depression Dep | 1 | | | | | | | | |
| Dry Throat/Mouth RESPIRATORY | | 1 | | | | | | | |
| [] Hay fever [] Hay fever [] Lipus [] Chronic Infection of Eye or Lid [] Chronic Bronchitis PSYCHIATRIC [] Depression [] Bipolar [] Emphysema [] Depression [] Bipolar [] Emdocrine [] Tired Eyes If you answered YES to any of the above or have a condition not listed, please explain: Depression [] Bipolar [] Findocrine [] Tired Eyes If you answered YES to any of the above or have a condition not listed, please explain: Depression [] Findocrine [] Tired Eyes If you answered YES to any of the above or have a condition not listed, please explain: Other: | | | SIC | | | | | | |
| []Asthma | 1 | I | | | | | | | |
| []Emphysema GASTROINTESTINAL []Diarrhea []Constipation Personal Eye History []Eye surgery []Eye injury or trauma []Eye infections []Lazy eye []Turned/crossed eye []Drooping eye lid []Prominent eyes []Glaucoma []Retinal disease []Cataract Other: Previous eye doctor: Family Eye History: Check all that apply to your blood relatives: []Glaucoma []Macular degeneration []Retinal Detachment []Blindness []Color vision defect []Crossed eye Family Medical History: Check all that apply to your blood relatives: []Clancer []Diabetes []Heart Disease []Hryroid Disease []Kidney Disease []Lupus Primary care physician | []Asthma | 1 = = = | | | | | | | |
| GASTROINTESTINAL []Diarrhea []Constipation Image: Blipolar Im | []Chronic Bronchitis | PSYCHIATRIC | | | | | | | |
| []Diarrhea []Constipation IEndocrine []Thyroid/Other Glands Or have a condition not listed, please explain: Other: | | | | | | | | | |
| Constipation []Thyroid/Other Glands explain: Other: | | | | | | | | | |
| Personal Eye History []Eye surgery []Eye injury or trauma []Eye infections []Lazy eye []Turned/crossed eye []Drooping eye lid []Prominent eyes []Glaucoma []Retinal disease []Cataract Other: Date of Last eye exam:/_/ Previous eye doctor: Family Eye History: Check all that apply to your blood relatives: []Glaucoma []Macular degeneration []Retinitis Pigmentosa []High myopia (near-sightedness) []Retinitis Pigmentosa []Blindness []Color vision defect []Crossed eye Family Medical History: Check all that apply to your blood relatives: []Arthritis [] Cancer []Diabetes []Heart Disease []High blood pressure []Kidney Disease []Lupus []Thyroid Disease Other: List any major injuries, surgeries and/or hospitalizations: Are you pregnant and/or nursing? □ Yes □ No List your allergies to medication or other substances: List any medication you are currently taking, including eye drops, oral contraceptives, aspirin, over the counter medications: When was the last time you saw your primary care physician / | 1 | | | I | | | | | |
| List any major injuries, surgeries and/or hospitalizations: Lazy eye | []Constipation | [] I nyroid/Other Glands | | CAPIGITI. | | | | | |
| []Eye surgery []Eye injury or trauma []Eye infections []Lazy eye []Turned/crossed eye []Drooping eye lid []Prominent eyes []Glaucoma []Retinal disease []Cataract Other: Date of Last eye exam:/_/_ Previous eye doctor: Family Eye History: Check all that apply to your blood relatives: []Glaucoma []Macular degeneration []Retinitis Pigmentosa []High myopia (near-sightedness) []Retinal Detachment []Blindness []Color vision defect []Crossed eye Family Medical History: Check all that apply to your blood relatives: []Arthritis [] Cancer []Diabetes []Heart Disease []High blood pressure []Kidney Disease []Lupus Other When was the last time you saw your primary care physician// Primary care physician's/_/ Primary care physician's// Primary care physician's/// Primary care physician's//// | | | | | | | | | |
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