CRYSTAL VISION CLINIC

Patient Registration

Date: _____/______/______

Last Name____________________________ First Name____________________ MI_______

Preferred Name:_________________________________ Date of Birth:______/______/______

Sex: M / F Spouses name/or if child Parent(s) Name:________________________________

Address:____________________________________City:____________________ State:____ Zip:_________

Home Ph:( )______________ Work Ph:( )_____________ Cell Ph:( )___________

How do you prefer we contact you? □Home Phone □Work Phone □Cell Phone □E-mail

Can we leave a message? □Yes □No Email Address:__________________________________

Employer/School:___________________________ Occupation/School Grade:________________________

Sports/Hobbies:________________________________ Who referred you to our office?______________

Ethnicity: □Caucasion □African American □Asian □Hispanic □American Indian □Other

Primary Language: □English □Chinese □Korean □Spanish □Vietnamese □Other

***WE MUST HAVE A COPY OF ALL INSURANCE CARDS ON THE DAY OF SERVICE**

IF YOUR INSURANCE IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:

Policy Holders Name:_____________________________ Policy Holders Date of Birth:_______________

Patient Relationship to Policy Holder: □Self □Spouse □Child □Other

Do you have vision ins. separate from your medical plan? □Yes □No Who is policy holder?_____________

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_________________________

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:________________________

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type:________________ Replace Schedule:_____________________

Have you ever had eye injuries? Yes No Which Eye?__________________________________

Have you ever had eye surgeries? Yes No Why?_______________________________________

Have you taken eye medication? Yes No Why?_______________________________________

Are you currently pregnant or nursing? Yes No

HAVE YOU EVER BEEN DIAGNOSED WITH?

Cataracts: Yes No When were you diagnosed?______________________________

Glaucoma: Yes No When were you diagnosed?______________________________

Macular Degeneration: Yes No When were you diagnosed?______________________________

Amblyopia (lazy eye): Yes No When were you diagnosed?______________________________

Strabismus (eye turn): Yes No When were you diagnosed?______________________________

**** PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE****

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ **None** ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other: ___ Medications______________	**Endocrine:** ___ **None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other: ___ Medications:______________	**Respiratory:** __ **None** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other: Medications:______________
Constitutional: __ **None** ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other: ___ Medications:______________	**Genitourinary:** __ **None** ___ Kidney Disease ___ Urinary Tract Infection ___ STD - Herpetic/Chlamydia ___ Other: ___ Medications:______________	**Psychiatric:** __ **None** ___ ADHD ___ Depression ___ Schizophrenia ___ Other: ___ Medications:______________
Neurological: __ **None** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other: ___ Medications:______________	**Musculoskeletal:** __ **None** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other: ___ Medications______________	**Immunologic:** __ **None** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other: ___ Medications:______________
Hematological: __ **None** ___ Anemia ___ Leukemia ___ Other: ___ Medications:______________	**Gastrointestinal:** __ **None** ___ Crohn's ___ Colitis ___ Other: ___ Medications______________	**Ear/Nose/Throat:** __ **None** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other: ___ Medications:______________
Dermatologic: __ **None** ___ Eczema ___ Rosacea ___ Psoriasis ___ Other: ___ Medications______________	**Allergies** (please list) __ **None** Drug: Environmental:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

____
____
____
____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

DISEASE / CONDITION

Blindness:	Yes	No	Who?______________________________
Cataracts:	Yes	No	Who?______________________________
Glaucoma:	Yes	No	Who?______________________________
Crossed Eyes:	Yes	No	Who?______________________________
Macular Degeneration:	Yes	No	Who?______________________________
Retinal Detachment:	Yes	No	Who?______________________________
High Blood Pressure:	Yes	No	Who?______________________________
Diabetes:	Yes	No	Who?______________________________
Cancer:	Yes	No	Who?______________________________
Heart Disease:	Yes	No	Who?______________________________
Thyroid Disease:	Yes	No	Who?______________________________

Who referred you to our clinic: Family Friend Yellow Pages Other (List)______________________

Reviewed by:

Dr ____ Date_______________