Northwest Optometry, LLC

Patient Registration Form

Welcome! *We appreciate the privilege of providing your eye and vision needs. Please complete this form as accurately and completely as possible. If you have any questions, please ask us. We are here to help.*

PATIENT INFORMATION FORM

First Name: ____________ MI: ______ Last Name: ______________ Today's Date______________

Mailing Address: ______________________ City: ____________ State: ________ Zip: ________

Telephone: ________________ Date of Birth: ____________ Age: __________ Sex: ________

Marital Status: __________ Social Security Number: ______________ Email: ______________

EMPLOYER INFORMATION:

Employer's Name: ________________________Occupation: ______________________

Address: ____________________ City: ____________ State: ________ Telephone: __________

RESPONSIBLE PARTY / PARENT / SPOUSE:

Name: ____________________________ Relationship: ________________________

Occupation: ______________________ Employer: ____________________________

Employers Address: ______________________________ Telephone: ________________

Social Security Number: ____________________

EMERGENCY CONTACT; OTHER THAN SPOUSE

Name: ____________________________ Relationship: ________________________

Contact's Address: ______________________________ Telephone: ________________

INSURANCE INFORMATION:

Insurance Company: ________________ Name of Policyholder: ____________ Date of Birth: ________

Address: ____________________________________ Telephone: ________________

Group Number: ________________________ Policy Number: ________________________

SUPPLEMENTAL INSURANCE INFORMATION:

Insurance Company: ______________________ Name of Policyholder: ________________

Address: ____________________________________ Telephone: ________________

Group Number: ________________________ Policy Number: ________________________

CURRENTLY TAKING THE FOLLOWING MEDICATION(S) – PRESCRIPTION & OVER-THE-COUNTER

1. I take ________________________ 4. I take ________________________

2. I take ________________________ 5. I take ________________________

3. I take ________________________ 6. I take ________________________

If you take additional medications, please list them below:

1. ____________ 2. ____________

FAMILY PHYSICIAN:____________________

Address: ________________________

DRUG ALLERGIES: ☐ Yes ☐ No

1. ____________________

2. ____________________

HEIGHT __________

WEIGHT __________

SURGERIES:	**DATE:**
____________________	________
____________________	________

ASSIGNMENT AND RELEASE

I, the undersigned; certify that I (or my dependant) have insurance coverage with ________________ and assign directly to Northwest Optometry, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

SIGNATURE: ______________________________________ **DATE:** ______________

REVIEW OF SYMPTOMS

PLEASE **CIRCLE** ANY PERSONAL HISTORY BELOW

CONSTITUTIONAL

Chills
Fatigue
Fever
Insomnia
Sleeping All the Time
Sudden Weight Gain
Sudden Weight Loss
Weakness

GENITOURINARY

Dialysis
Benign Prost Hyperplasia
Benign Prost Hypertrophy
Bladder Infections
Bladder Repairs
Bladder Spasms
BPH
Changes in Color of Urine
Vasectomy
Endometriosis
Frequent urination
Incontinence
Kidney Failure
Kidney Infections
Kidney Stones
Kidney Transplant
Menopause symptoms
Ovarian Cancer
Ovarian Cysts
Prostate cancer
Recur. Urinary Tract Infection
Renal Stricture
Renal Cancer
STD
Testicular Cancer
Uterine Fibroids
Uterine Cancer
Vulvular Cancer

IMMUNOLOGIC/ ALLERGY

Sulfa
Penicillin
Allergy Shots
Chemicals
Diagnostic Agents
Environmental
HIV
Immune Disorder
Latex
Lupus
Sulfonamides
Other antibiotics
Seasonal Allergies

PSYCHIATRIC

ADHD
Agitated
Anxiety
Appropriate
Bipolar
Confused
Dementia
Depression
Insomnia
Irritability
Mood Swings

CARDIOVASCULAR

Arrhythmia
Bypass Graft
Bypass Surgery
Chest Pain
Congestive Heart Failure
Coronary Artery Disease
Cyanosis
DVT
Heart Disease
Heart Murmur
Heart Palpitation
High Cholesterol
History of Heart Disease
Hypertension (HTN)
Irregular Heart Beat
Mitral Valve Prolapse
Pacemaker
Shortness of Breath
Stent(s)
Stroke
Valve Replacement
Rheumatic Heart Valve Disease
Hypercholesterolemia
Cardiomyopathy
Carotid Artery Disease
Atrial Fibrillation
Hypotension
Hypertriglyceridemia

GASTROINTESTINAL

Ulcers
Abdominal Pain
Benign Prostatic Hyperplasia
Bowel Cancer
Change in Appetite
Collitis
Constipation
Crohn's Disease
Diarrhea
Difficulty Swallowing
Diverticulitis
Esophagitis
Frequent Bowel Movements
Gall Bladder Disease
Gastric Reflux
GERD
Heartburn
Hemorrhoids
Hepatitis Type- A, B or C
Hernia
Indigestion
Irritable Bowel Syndrome
Jaundice
Nausea
Pancreatitis
Stomach Cancer

PSYCHIATRIC-CONTINUED

Nervousness
Oriented
Panic Episodes
Paranoia
Suicidal Thoughts
Violent
Alzheimers

EARS/NOSE/THROAT/MOUTH

Chronic Colds
Chronic Sinusitis
Chronic Strep Infections
Ear Infections
Ear Itching
Ear Pain
Hearing Aid(s)
Hearing Loss
Mouth Sores
Nose Bleeds
Otitis Media
Ringing in Ears
Runny Nose
Sinus Pain
Sore Throat
Stuffy Nose

NEUROLOGICAL

Vertigo
ADHD
Aphasia
Bell's Palsy
Cerebral Palsy
Cranial Nerve Palsy
Dizziness
Epilepsy
Friedrich's Ataxia
Headache
Herpes Zoster
Herpes Zoster Ophthalmicus
Involuntary Movement
Migraines
Myasthenia Gravis
Paralysis
Parkinson's Disease
Peripheral Neuropathy
Seizures
Stroke
TIA
Transient Visual Obstructions (TVO)

ENDOCRINE

Type 1 Diabetes
Type 2 Diabetes
Adrenal Gland Disorder
Diet Controlled Diabetes
Gestational Diabetes
Hyperadrenal Gland
Hyperthyroidism
Hypoadrenal Gland
Hypoglycemia
Hypothyroidism
Metabolic Syndrome
Oral Hypoglycemic
Prediabetes

RESPIRATORY

Asthma
Bronchitis
Chronic Bronchitis
Chronic Cough
Collapsed Lung History
COPD
Emphysema
Lung Cancer
Pleurisy
Pneumonia
Sarcoid
Shortness of Breath
Sleep Apnea
Tuberculosis

MUSCULOSKELETAL

Rheumotoid Arthritis
Ankylosing Spondylitis
Arthritis
Back Pain
Bone Cancer
Cerebral Palsy
Fibromyalgia
Fracture
Gout
Joint Pain
Juvenile Rheum.Arthritis
Limited Range of Motion
Lumbar Disc Disease
Multiple Sclerosis
Muscle Pain
Muscular Dystrophy
Myasthenia Gravis
Neck Pain
Osteoarthritis
Osteoporosis
Polymyalsia

INTEGUMENTARY

Skin Cancer
Skin Rash
Acne Rosacea
Bruising
Changes in Pigment
Changes in Nails/Hair
Dermatitis
Dryness
Eczema
Excessive Sweating
Itching
Onchyomycosis
Psoriasis

HEMATOLOGIC

Thrombocytopenia
Lyme Disease
Lymphoma
Anemia
Blood Disorders
Factor V Leiden
Enlarged Lymph Nodes
Hemachromatosis
Hemophilia
Leukemia

DATE_______________

SIGNATURE OF PATIENT______________________________

SIGNATURE OF DOCTOR ______________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with ____________________

and assign directly to Northwest Optometry, LLC all insurance benefits. If any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether not paid by insurance. I authorize the use of this signature on all insurance submissions.

SIGNATURE: ____ DATE: ______________________