EYECARE REGISTRATION

DIANE S. DIBLE, O.D., *SHANE M. MAAG, O.D.*

Patient Name: ____ **Date:** __________

If minor, parent's names: ____

Address: ________________________________ Home Phone: ______________ Cell Phone: ____________

Street/PO Box City State Zip

Patient SS #: ____________________ Home e-mail: ____________________

Occupation: ____________________ Gender: ____ Male ____ Female Marital Status: ____ Single ____ Widowed ____ Married ____ Divorced

Work Phone: ____________________

Employer: ____________________ Age: ______ Birthdate: ____________________

Spouse's Name: ____________________ Birthdate: ______________ Spouse's SS #: ______________

Spouse's Occupation: ______________ Work Phone: ______________ Employer: ____________________

HIPAA Contacts/Release of Information:

Name 1. ________________________ Relationship ______________ Phone: ______________

2. ________________________ Relationship ______________ Phone: ______________

3. ________________________ Relationship ______________ Phone: ______________

HEALTH HISTORY		**YOUR EYE HEALTH HISTORY**	
Do you have any of the following medical conditions? ***Please circle*** YES ***or*** NO		Have you ever had any of the following eye or ocular problems? ***Please circle*** YES ***or*** NO	
Airborne Allergies	Yes No	Cataracts	Yes No
Food Allergies List allergies:	Yes No	Color Blindness Glaucoma	Yes No Yes No
Allergies to Medications *(List allergies to medications on back where indicated.)*	Yes No	Detached Retina Eye Injury	Yes No Yes No
Arthritis	Yes No	Turned Eye	Yes No
Cancer Type: Date of Diagnosis:	Yes No	Eye Surgery Type: Date of Surgery:	Yes No
Diabetes Type: Date of Diagnosis:	Yes No	Lazy Eye/Amblyopia Macular Degeneration	Yes No Yes No
Heart Disease	Yes No		
High Blood Pressure	Yes No	**YOUR FAMILY'S HEALTH HISTORY**	
Low Blood Pressure	Yes No	Blindness	Yes No
Kidney Disease	Yes No	Cataracts	Yes No
Liver Disease	Yes No	Color Blindness	Yes No
Lung Disease	Yes No	Detached Retina	Yes No
Migraine Headache	Yes No	Lazy Eye	Yes No
Muscle/Bone Disease	Yes No	Macular Degeneration	Yes No
Neurological Problems	Yes No	Diabetes	Yes No
Sinus Problems	Yes No	Glaucoma	Yes No
Skin Disorder	Yes No	Heart Disease	Yes No
Stomach/Digestive	Yes No	High Blood Pressure	Yes No
Stroke.	Yes No	Stroke	Yes No
Thyroid Problems	Yes No	Other:	
High Cholesterol	Yes No	Other:	
Other:		Other:	

OVER ⇨

VISION INSURANCE

MEDICATIONS List Enclosed ☐
List medications you are currently taking, including eye drops:
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ALLERGIES TO MEDICATIONS		
List any allergies to medications you are aware of:		
1.	4.	
2.	5.	
3.	6.	
Do you use cigarettes/tobacco?		Yes No
Do you use alcohol?		Yes No
Do you use other substances?		Yes No
IF FEMALE: please answer the following:		
Are you taking birth control pills?		Yes No
Are you pregnant at this time?		Yes No
Name of Pharmacy:		
Location:		
Family Doctor:		

Name of person carrying the insurance: ____ Insured's Birthdate:__________
Relationship to Patient: ____ SS#: ________________________
Insurance Co. ____________________________________ Employer _________________ Group #: ___________________

Are you a **student**? ____ Yes ____ No Full-time ☐ Part-time ☐

MEDICAL INSURANCE

☐ Medicare

Name of person carrying the insurance: ____ Insured's Birthdate:__________
Relationship to Patient: ____ SS#: ______________________
Insurance Co. ____________________________________ Employer _________________ Group #: ___________________

Do you have additional insurance? ___ Yes ___ No
If you DO have additional insurance, please complete the following:
Name of person carrying 2nd insurance: ____ Insured's Birthdate:__________
Relationship to Patient: ____ SS #:________________________
Insurance Co. __________________________________ Employer _________________ Group #: ___________________

AUTHORIZED SIGNATURE

I have reviewed or revised my "Eyecare Registration" form and the information is correct and current. By signing this form, I agree to authorize payments made on my behalf to Ottawa Eyecare for services furnished. My signature authorizes release of the information to the insurer.

Please sign and date one time at each visit.

Date:	Signature:
Date:	Signature:
Date:	Signature:
Date:	Signature: