VISUALLY SOUND
OPTOMETRY

Clear Form

PATIENT REGISTRATION FORM

Please print clearly. Fill in each section if you are a new patient. If you are an existing patient, please only update the sections that have new information.

☐ No changes to the information below

PATIENT INFORMATION

Name: _____

Gender: ☐ M ☐ F Date of Birth: ___ /___ /_____

Address: _____

City, State, Zip: _____

Home Phone: _____ ☐

Cell Phone: _____ ☐

Work Phone: _____ ☐

(Please check the box next to the best phone number to reach you)

Employer Name: _____

Email Address: _____

PARENT/GUARDIAN INFORMATION

(Required for minor only)

Name: _____

Gender: ☐ M ☐ F Date of Birth: ___ /___ /_____

Address: _____

City, State, Zip: _____

Home Phone: _____ ☐

Cell Phone: _____ ☐

Work Phone: _____ ☐

(Please check the box next to the best phone number to reach you)

Employer Name: _____

Email Address: _____

INSURANCE INFORMATION

Vision Plan Name: _____

Primary Member Name _____

Primary Member Date of Birth: ___ /___ /_____

Member ID #: _____

Medical Plan Name _____

Primary Member Name _____

Member ID #: _____

PCP's Name: _____

(Used for Referral or Diabetic Letter Purposes Only)

MEDICAL HISTORY INFORMATION

Last Eye Exam: ___ /___ /_____ Office/Doctor Name: _____

Do you wear glasses?

☐ NO ☐ YES ☐ ALL THE TIME ☐ OCASSIONALLY ☐ DISTANCE ONLY ☐ NEAR ONLY

Do you wear contacts?

☐ NO ☐ YES Brand: _____ ☐ Not Sure Cleaning Solution: _____ ☐ Not Sure

How often do you replace your lenses? _____ ☐ Not Sure How often do you sleep in the lenses? _____ /month

Please check the box if any of these eye conditions apply to you:

☐ GLAUCOMA ☐ MACULAR DEGENERATION ☐ STRABISMUS (EYE TURN)

☐ AMBLYOPIA (LAZY EYE) ☐ KERATOCONUS ☐ EYE INJURY

☐ CATARACTS ☐ RETINAL DISEASE ☐ OTHER _____

Please check the box if any of these health conditions apply to you:

☐ ASTHMA ☐ SEASONAL ALLERGIES ☐ HIGH BLOOD PRESSURE
☐ DIABETES TYPE I/TYPE II ☐ HIGH CHOLESTEROL ☐ THYROID DYSFUNCTION
☐ AUTOIMMUNE DISEASE ☐ CANCER ☐ HEART DISEASE
☐ KIDNEY DYSFUNCTION ☐ OTHER _____

Please list all your medication below:

_____

_____

_____

Do you currently take or have taken the medication Hydrochloroquine/Chloroquine (Plaquenil)? ☐ NO ☐ YES

Are you allergic to any medication? If so, please list medication and allergic reaction.

_____

_____

Please check the box if you have had any of the following eye surgeries:

☐ LASIK/PRK ☐ CATARACT REMOVAL ☐ RETINAL TEAR/DETACHMENT
☐ RETINAL LASER ☐ EYE INJECTION ☐ PINGUECULA/PTYERGIUM REMOVAL
☐ CXL/KERATOCONUS ☐ EYE LID SURGERY ☐ OTHER _____

Please check the box if any of your family members currently have/or have been treated for these conditions:

☐ GLAUCOMA ☐ MACULAR DEGENERATION ☐ STRABISMUS (EYE TURN)
☐ AMBLYOPIA (LAZY EYE) ☐ BLINDNESS ☐ EYE INJURY
☐ DIABETES TYPE I/TYPE II ☐ AUTOIMMUNE DISEASE ☐ OTHER _____

Please check the box if you currently use the following:

☐ TOBACCO How many packs/day: _____ Number of years: _____
☐ ALCOHOL Approximately, how many drink(s)/day: _____
☐ DECLINE TO ANSWER

PATIENT #: _____