NORMAN EYE ASSOCIATES, P.C.

PATIENT REGISTRATION AND MEDICAL HISTORY

Today's Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail address (optional) _____

Communication Preference: phone (#_____)

Date of Birth _____ Social Security No. _____ Sex ☐ M ☐ F

Place of Employment _____

Marital Status _____ Spouse's Name _____

Spouse's Place of Employment _____ Phone # _____

Patient's Preferred language _____

If minor, Parent Name _____ Phone # _____

Person responsible for account _____ Relationship _____

Address (if different from patient) _____ Phone # _____

INSURANCE INFORMATION

Insurance Company (Medical) _____ ID # _____

Member's Name _____ Member's birth date _____ Relationship _____

Insurance Company (Vision) _____ ID # _____

Member's Name _____ Member's birth date _____ Relationship _____

EYE HISTORY

Date of Last Eye Exam _____ Dilated? ___ Yes ___No

Currently Wear Glasses? ___Yes ___No If yes, for what activity? _____

Currently Wear Contacts? ___Yes ___No If yes, brand/type _____

Reason for Today's Visit _____

_____

Have you or your parents, grandparents, or siblings experienced, or been treated for, any of the following? Check all that apply.

Cataracts (removed___)	yourself	family member (who)
Crossed Eye	yourself	family member (who)
Glaucoma	yourself	family member (who)
LASIK or RK	yourself	family member (who)
Lazy Eye	yourself	family member (who)
Macular Degeneration	yourself	family member (who)
Retinal Detachment	yourself	family member (who)

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry vision: __*near* __*distance* __*both*
- ☐ Burning
- ☐ Discharge
- ☐ Double vision or shadowing
- ☐ Dryness
- ☐ Excess tearing/watering
- ☐ Eye infection
- ☐ Eye pain or soreness
- ☐ Floaters or spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light flashes
- ☐ Light sensitivity
- ☐ Redness
- ☐ Sandy or gritty feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

AIDS/HIV	yourself	family (who)
Allergies	yourself	family (who)
Arthritis	yourself	family (who)
Asthma	yourself	family (who)
Blood/lymph disorder	yourself	family (who)
Cancer	yourself	family (who)
Diabetes	yourself	family (who)
Ears, nose, throat conditions	yourself	family (who)
Gastrointestinal conditions	yourself	family (who)
Heart disease	yourself	family (who)
High blood pressure	yourself	family (who)
High cholesterol	yourself	family (who)
Kidney disease	yourself	family (who)
Lupus	yourself	family (who)
Neurological conditions	yourself	family (who)
Psychiatric disorder	yourself	family (who)
Seizures	yourself	family (who)
Skin conditions	yourself	family (who)
Stroke	yourself	family (who)
Thyroid dysfunction	yourself	family (who)

Current Medications, including homeopathic remedies, birth control pills, and over-the-counter meds:

_____

_____

Medication Drug Allergies: _____

_____

(Women) Are you currently pregnant or nursing?___ Yes ___No

Family Physician_____ Phone # _____

GETTING TO KNOW YOU

Whom may we thank for referring you to our office? _____

Is another family member a patient in our office?_____

Contact person and phone number in case of emergency _____

HIPAA

I acknowledge the opportunity to review or request the Notice of Privacy Practices. I give consent to disclose protected health information to carry out health operations, treatment, and payment.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I/my minor child is covered by (name of insurance company)_____ and assign directly to Norman Eye Associates/Dr. Geurkink all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that with the many different insurance companies and plans, Dr. Geurkink may not be participating in my particular plan.

FINANCIAL AGREEMENT

I understand it is customary to pay for professional services at the time they are rendered unless other arrangements are made. When materials are required, half of the fee is expected on ordering. The balance is due upon dispensing.

I agree that I am responsible for all fees and services rendered for examination/treatment of myself/my minor child. I accept full financial responsibility for all charges for services or items provided to me or the patient.

Although I may have insurance coverage, I understand and agree to be responsible for all fees billed to my insurance company should payment be declined.

To the best of my knowledge, the information provided on this form is complete and correct.

Signed (patient/guardian) _____ Date _____