DESERT FAMILY EYE CARE
REGISTRATION FORM
(Please Print)

First Name:	Last:	MI:	Suffix:	Nickname:	
Street Address or P.O. Box		City:	State:	ZIP:	
Last 4 SSN: ***-**-_____	Email Address:				
Date of Birth:	Sex: ☐ Male ☐ Female ☐ Undisclosed				
Cell Phone ( ) _____-_____	Home Phone ( ) _____-_____	Work Phone ( ) _____-_____	Other Phone ( ) _____-_____		
Preferred Method of Contact: ____Home ____Cell ____Work ____Other ____Email	Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Legally Separated ☐ Married ☐ Never Married ☐ Widowed ☐ Undisclosed				
Occupation: _____ Employer: _____	School Name: _____ ☐ Full-Time Student ☐Part-Time Student				

VISION INSURANCE INFORMATION

Primary Insurance Name:
☐VSP ☐ M.E.S ☐ EYEMED ☐ DAVIS VISION ☐ MEDICARE ☐ UFCW ☐ NONE ☐ OTHER_____

Subscriber Name: _____ Insurance I.D #:_____ Subscriber Date of Birth:_____ Subscriber SSN:_____	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Name:
☐VSP ☐ M.E.S ☐ EYEMED ☐ DAVIS VISION ☐ MEDICARE ☐ UFCW ☐ NONE

Subscriber Name: _____ Insurance I.D #:_____ Subscriber Date of Birth:_____ Subscriber SSN:_____	Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

MEDICAL INSURANCE INFORMATION

PCP NAME: _____ ***PCP Phone:***_____ **☐HMO or ☐PPO**

☐HEALTHNET ☐ MEDICARE ☐ BLUECOSS ☐ BLUESHIELD ☐ CIGNA ☐ NONE ☐ OTHER_____

Subscriber Name: _____
Insurance I.D #:_____
Subscriber Date of Birth:_____
Subscriber SSN:_____

Patient's relationship to subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Name:
☐HEALTHNET ☐ MEDICARE ☐ BLUECOSS ☐ BLUESHIELD ☐ CIGNA ☐ NONE ☐ OTHER_____

Subscriber Name: _____
Insurance I.D #:_____
Subscriber Date of Birth:_____
Subscriber SSN:_____

Patient's relationship to subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other

REASON FOR VISIT - (*Please Check All That Apply)*

☐Routine Exam ☐Distance Blur ☐Near Blur ☐Computer Fatigue ☐Strain ☐Burn ☐Watery ☐Pain ☐Red ☐Floaters
☐Flashes ☐ Double Vision ☐Light Sensitivity ☐Itchy ☐Decreased side vision ☐Grittiness ☐Halos ☐Headache ☐Irritation
☐Wants to be fitted for contacts ☐Other:_____

CONTACT LENS HISTORY

Do you currently wear contacts? ☐Yes ☐ No		Have you ever worn contacts? ☐Yes ☐ No	
Brand Name:	Power Right Eye:	Power Left Eye:	
How often do you replace lenses: ☐ Daily ☐ Weeks ☐ Month ☐ Yearly			
Solution use:	☐Optifree Puremoist ☐Renu ☐Boston ☐Clear Care ☐Bio True ☐Other:		

(Please Continue on Back)

EYE HISTORY **MEDICAL HISTORY**

Which of the following conditions apply to you:

☐Glaucoma ☐ Floaters
☐Retinal Detachment ☐Cataract
☐Amblyopia/Strabismus ☐Blindness
☐Crossed Eyes ☐Lazy Eye
☐Color Blindness ☐Double Vision
☐Serious Eye Infection ☐Flashes
☐Age Related Macular Degeneration
☐Other/None_____
_____
_____

Eye Surgeries

☐NONE
☐Lasik
☐PRK/RK
☐Cataract
☐Retinal
☐Eyelid
☐Other:_____
_____
_____

☐ Diabetes
☐High Blood Pressure
☐Thyroid
☐Cardio Vascular Disease
☐Cancer
☐Arthritis
☐Asthma
☐Emphysema
☐Headaches/Migraines
☐None
☐Other:_____

Any Serious Eye Injuries ***Yes*** *or* ***No*** *(If yes, please describe):* _____
_____

MEDICAL HISTORY CONTUINE

Please Circle All That Apply)

Allergies/Immunologic	NONE	Allergies	Hay Fever				
Bones/Joints/Muscles	NONE	Muscle/Joint Pain	Rheumatoid Arthritis	Swollen joints			
Cardiovascular	NONE	Chest Pain	Circulatory/Vascular Disease	Heart	Cholesterol	Stroke	
Constitutional (Current)	NONE	Fatigue Fever	Weight Change				
Ears/Nose/Throat	NONE	Chronic Cough	Dry Mouth	Runny Nose	Sinus Congestion		
Endocrine	NONE	Diabetic	Neck pain	Other glands	Thyroid		
Gastrointestinal	NONE	Nausea	Vomiting	Constipation	Ulcers	Hernia	
Genitourinary	NONE	Genitals	Kidney/Bladder				
Integumentary (Skin)	NONE	Excessive Dryness	Itch	Rash			
Lymphatic/Hematologic	NONE	Anemia	Bleeding Problems	Blood Disorders			
Nervous System	NONE	Dizziness	Headaches	Mult.Sclerosis	Numbness	Paralysis	Seizures
Psychiatric	NONE	ADHD	Anxiety	Depression	Special Needs	Insomnia	
Respiratory	NONE	Asthma	Bronchitis	Cough	Emphysema	Short of Breath	Wheezing

FAMILY MEDICAL HISTORY

Which of the following conditions apply to your parents, grandparents, siblings, children (living or deceased)?

(Please Circle All That Apply)

Glaucoma	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Age Related Macular Degeneration	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Retinal Detachment	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Cataract	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Amblyopia/Strabismus	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Blindness	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Diabetes	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Hypertension	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Thyroid	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Cardio Vascular Disease	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Cancer	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Other:	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE
Other:	Mom	Dad	Sibling	P-GM	P-GF	M-GM	M-GF	Children	NONE

AUTHORIZATION AND RELEASE

- I authorize Desert Family Eye Care to release my medical information to the Health Care Financing Administration concerning information needed to determine benefits or benefits payable for services.
- I acknowledge I have provided all of my current insurance information and I understand that I am fully responsible for any overage fees or portions left unpaid by my insurance company(s).

Print Patient Name:_____

Patient Signature (Parent/Guardian):_____Date_____