Kelly eye center *for sight*

# PATIENT REGISTRATION FORM

**Today's Date:** _____

**Patient Name:** Mr. Mrs. Ms. Dr. _____

**Date of Birth:** _____ **SSN:** _____ ☐ Male ☐ Female

**Address:** _____

**Home Number:** _____ **Cell Phone:** _____

**Email Address:** _____ **Marital Status:** _____

**Race:** ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

**Language:** ☐ English ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Other: _____

**North Carolina Resident:** ☐ Full Time ☐ Part Time If Part Time, please complete information below.

From: _____ To: _____ Secondary Home Phone: _____

Secondary Address: _____

Eye Physician: _____ Phone: _____ Fax: _____

**Responsible Party Information (If different from above):**

Name: _____ Date of Birth: _____

**Primary Insurance:** _____ **Policy #:** _____

**Secondary Insurance:** _____ **Policy #:** _____

**Are you or your spouse employed full time or part time?** ☐ Yes ☐ No

**If so, do you have health insurance through your employer?** ☐ Yes ☐ No

**Are you enrolled in an HMO?** ☐ Yes ☐ No

**Do you need authorization from your Primary Physician to see a specialist?** ☐ Yes ☐ No

**Have you been in a skilled nursing a facility and/or hospice care in the past 6 months?** ☐ Yes ☐ No

If yes, what is the name of the Facility? _____

**How did you hear about Kelly Eye Center?** ☐ Billboard/Building Signage ☐ Doctor ☐ Event

☐ Family/Friend ☐ Google/Online Search ☐ Other: _____

**Emergency Contact:** _____

Relationship: _____ Phone: _____

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Patient Name: _____ Date of Birth: _____ Today's Date: _____

**Primary Care Physician:** _____ Phone: _____

Address: _____ Fax: _____

**Primary Eye Physician:** _____ Phone: _____

Address: _____ Fax: _____

**Height:** _____ **Weight:** _____ **Have you fallen in the last year?** ☐ Yes ☐ No

**Ocular History:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Cataracts | ☐ Yes | ☐ No | LASIK / Epi-LASEK |
| ☐ Yes | ☐ No | Cornea Transplant | ☐ Yes | ☐ No | Macular Degeneration |
| ☐ Yes | ☐ No | Diabetic Retinopathy | ☐ Yes | ☐ No | Punctal Plugs |
| ☐ Yes | ☐ No | Dry Eye Syndrome | ☐ Yes | ☐ No | Retinal Detachment |
| ☐ Yes | ☐ No | Glaucoma | ☐ Yes | ☐ No | YAG Laser |

☐ Other: _____

**What is the reason for your visit today?**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐ Blurred Vision | RT | LT | ☐ Dry Eyes | RT | LT | ☐ Itching | RT | LT |
| ☐ Decreased Vision | RT | LT | ☐ Flashes | RT | LT | ☐ Pain | RT | LT |
| ☐ Discharge | RT | LT | ☐ Floaters | RT | LT | ☐ Red Eye | RT | LT |
| ☐ Double Vision | RT | LT | ☐ Headache | RT | LT | ☐ Tearing | RT | LT |

☐ Other: _____

**Immunization / Vaccination:**

☐ Yes ☐ No Influenza Date/s: _____

☐ Yes ☐ No Pneumococcal Date: _____

**Surgical History:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Appendectomy | ☐ Yes | ☐ No | Hemorrhoidectomy |
| ☐ Yes | ☐ No | Carotid Endarterectomy | ☐ Yes | ☐ No | Hysterectomy |
| ☐ Yes | ☐ No | Gallbladder | ☐ Yes | ☐ No | Mastectomy |
| ☐ Yes | ☐ No | Heart Bypass | ☐ Yes | ☐ No | Prostate |
| ☐ Yes | ☐ No | Hernia | ☐ Yes | ☐ No | Skin Cancer Removal |

☐ Other: _____

**Allergies:**

☐ Yes ☐ No Latex Please describe: _____

☐ Yes ☐ No Anesthesia Please describe: _____

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Patient Name: _____ Date of Birth: _____ Today's Date: _____

**Family History:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Cataracts | ☐ Mother | ☐ Father | ☐ Other: _____ |
| ☐ Yes | ☐ No | Diabetes | ☐ Mother | ☐ Father | ☐ Other: _____ |
| ☐ Yes | ☐ No | Glaucoma | ☐ Mother | ☐ Father | ☐ Other: _____ |
| ☐ Yes | ☐ No | Macular Degeneration | ☐ Mother | ☐ Father | ☐ Other: _____ |
| ☐ Yes | ☐ No | Retinal Detachment | ☐ Mother | ☐ Father | ☐ Other: _____ |
| ☐ Other: _____ | | | ☐ Mother | ☐ Father | ☐ Other: _____ |

**Social History:**

Occupation: _____ ☐ Retired ☐ Disabled ☐ Not Working

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Walking ☐ Other: _____

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

**Past / Present Medical History:**

| | | | | | |
|---|---|---|---|---|---|
| ☐ Yes | ☐ No | Abdominal Pain | ☐ Yes | ☐ No | Hearing Loss |
| ☐ Yes | ☐ No | Alzheimer's | ☐ Yes | ☐ No | Heart Attack: Year _____ |
| ☐ Yes | ☐ No | Anxiety | ☐ Yes | ☐ No | High Blood Pressure/Hypertension |
| ☐ Yes | ☐ No | Arthritis | ☐ Yes | ☐ No | Irregular Heartbeat |
| ☐ Yes | ☐ No | Asthma | ☐ Yes | ☐ No | Kidney Disease |
| ☐ Yes | ☐ No | Autoimmune Disease | ☐ Yes | ☐ No | Kidney Failure |
| ☐ Yes | ☐ No | Bleeding | ☐ Yes | ☐ No | Kidney Stones |
| ☐ Yes | ☐ No | Bruises | ☐ Yes | ☐ No | Migraine |
| ☐ Yes | ☐ No | Cancer | ☐ Yes | ☐ No | Nausea |
| ☐ Yes | ☐ No | Cardiovascular Disease | ☐ Yes | ☐ No | Parkinson |
| ☐ Yes | ☐ No | Cholesterol | ☐ Yes | ☐ No | Psoriasis |
| ☐ Yes | ☐ No | COPD | ☐ Yes | ☐ No | Seasonal Allergies |
| ☐ Yes | ☐ No | Dementia | ☐ Yes | ☐ No | Sinus Problems |
| ☐ Yes | ☐ No | Depression | ☐ Yes | ☐ No | Skin Rashes |
| ☐ Yes | ☐ No | Diabetes: Type 1 or Type 2 | ☐ Yes | ☐ No | Stroke: Year _____ |
| ☐ Yes | ☐ No | Headaches | ☐ Yes | ☐ No | Stomach Ulcers |
| ☐ Yes | ☐ No | Hearing Aides | ☐ Yes | ☐ No | Thyroid Disease |

☐ Other: _____