KENAI VISION CENTER – Vision Source®

PATIENT REGISTRATION INFORMATION

Today's Date: ____________

First Name: ______________________ M.I.____ Last Name________________________ Preferred Name__________________

SSN: ______-____-________ Date of Birth _____/_____/_____ Gender: □ Male □ Female

Mailing Address: ____

City, State, Zip Code: ____

Home Phone______-_______-________ Cell Phone______-_______-_________ Work Phone______-_______-________

May we leave phone messages for exams or materials? ______ Email Address: _____________________________________

Marital Status: _______________________________ Spouse Name____

Language: ______________ Race: ________________ Ethnicity: _____________________

Employer: ____ Occupation: ___________________________

If not same as the person above

RESPONSIBLE PARTY

Name of Person Responsible for this Account: ____________________________ Relationship to Patient_____________

Address____ Phone: ______-______-________

SSN: ______-____-________ Date of Birth____/____/____ Employer: ____

INSURANCE INFORMATION

Please provide us with the insurance card as well, so that we may scan it into the computer

#1) Insurance Carrier: _____________________________________ Employer: _____________________________________

Group #:____________________________ID# __________________________________ ʘ Vision ʘ Medical

Relationship to Patient □ Self □ Spouse □ Dependant □ Other_______

If subscriber is someone other than the patient, please complete the following:

SSN: ______-____-________ First Name: ___________________MI:__________ Last Name: __________________________
Sex: □ M □ F Date of Birth: ____/____/____

#2) Insurance Carrier: __________________________________ Employer: ________________________________

Group #:____________________________ ID# ___________________________________ ʘ Vision ʘ Medical

Relationship to Patient □ Self □ Spouse □ Dependant □ Other_____________

If subscriber is someone other than the patient, please complete the following:

SSN: ______-____-________ First Name: ___________________MI:__________ Last Name: __________________________
Sex: □ M □ F Date of Birth: ____/____/____

Kenai Vision Center requires payment at the time services are rendered unless arrangements are made in advance

I authorize release of information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also herby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also acknowledge that I received and /or was offered a copy of Kenai Vision Center Notice of Privacy Practices.

Signature: ____ Date: _____/_____/_____

PATIENT HISTORY FORM

First Name: ______________________ M.I.____ Last Name________________________ Preferred Name_________________

Medical Doctor: _______________________________________ Pharmacy: ____

Date of Last Eye Exam, *if not at Kenai Vision*: ____/____/____ Location of Eye Exam:____________________________________

Currently wear glasses? Y/N Reading Glasses? Y/N Contact Lenses? Y/N Soft or Rigid Gas Permeable?___________________

Brand/Type of Contacts: ____

Medications and Supplements:____

Medication Allergies: ______________________________________Reaction: ____

Height: ______ Weight: ______ Use of Tobacco Y/N Alcohol Y/N Drugs: Y/N Please explain: _____________________________

REVIEW OF SYSTEMS- Do you currently have any of the following problems?

System	Y	N	Date Diagnosed	Condition/Current Treatment/Surgery
Eye Diseases, Eye Injury, Eye Surgery	Y	N		
Allergic/Immunologic (allergic to what, and What is the reaction?)	Y	N		
Cardiovascular (heart, high blood pressure)	Y	N		
Constitutional (fever, weight loss, other)	Y	N		
Endocrine (thyroid)	Y	N		
Gastrointestinal (heartburn, GERD, acid Reflux)	Y	N		
Genitourinary (male or female problems, Urinary problems, kidneys)	Y	N		
Ears (reduced hearing or hearing loss)	Y	N		
Nose/Mouth/Throat (sinus problems, sore throat)	Y	N		
Hematologic (bleeding issues, anemia)	Y	N		
Autoimmune (lupus, rheumatoid arthritis, etc)	Y	N		
Dermatologic (skin rashes, excessive dryness)	Y	N		
Musculoskeletal (muscle or joint problems)	Y	N		
Neurological (weakness, stroke, paralysis)	Y	N		
Psychiatric (depression)	Y	N		
Respiratory (breathing problems, lung Issues)	Y	N		
Diabetes	Y	N		Type I or Type 2 A1C#?
Cancer (type)	Y	N		
Operations	Y	N		
Other	Y	N		

FAMILY HISTORY			RELATION (Maternal/Paternal) DATE OCCURED
High Blood Pressure	Y	N	
Diabetes	Y	N	
Glaucoma	Y	N	
Cataracts	Y	N	
Retinal detachment	Y	N	
Macular Degeneration	Y	N	
Other Eye Conditions	Y	N	

*** If any of the above two questionnaires are left blank, we will assume your answer is "NO".**