Welcome to MOUNT VERNON EYE CARE, PC

New patient's registration form (**please fill out front and back**)

Today's Date: _____

PATIENT'S INFORMATION					
Last Name:	First Name:		Middle Initial:	Salutation:	
DOB:	Gender: F☐M☐	Marital Status:		Social Security:	
Race:	Ethnicity:	Primary Language:		Special Needs:	
Street address:		City:	State:	Zip:	
Country:	Type: ☐*home* ☐*work* ☐*mailing* ☐*temporary* ☐*vacation*				
☐Home Phone:	☐Work Phone:	☐Cell Phone:			
☐Email:	*Please indicate preferred type of communication (**X**)*				
Occupation:	Employer:				
How did you find out us?					
Referring physician's name:		Phone #:			
Family physician's name:		Phone #:			

INSURANCE INFORMATION		
Routine vision insurance:	Primary Subscriber's name:	
Relation to the patient:	Policy Id #:	Subscriber's DOB:
Primary medical insurance:	Primary Subscriber's name:	
Relation to the patient:	Policy Id #:	Subscriber's DOB:
Secondary medical insurance:	Primary Subscriber's name:	
Relation to the patient:	Policy Id #:	Subscriber's DOB:

ACCOUNT RESPONSIBLE INFORMATION				
Name:	Phone #:	DOB:	Relation to the patient:	
Street address:		City:	State:	Zip:

IN CASE OF EMERGENCY		
Name:	Phone #:	Relation to the patient:

SOCIAL HISTORY	
Do you smoke? Yes☐No☐	Do you drink alcohol? Yes☐No☐
Are you pregnant? Yes☐No☐	Have you been pregnant in the past 6 months? Yes☐No☐
What hobbies or sport do you participate in?	

OCCULAR HISTORY	
Date of your last eye exam:	Name of the doctor:
Do you wear glasses? Yes☐No☐	**When do you wear glasses?** ☐*All the time* ☐*Near/Intermediate*☐*Distance*☐*Work Safety*
Have you ever worn contact lenses? Yes☐No☐	☐*Daily Wear* ☐*Extended Wear* ☐*Multi-focal Wear* ☐*Keratoconus Wear*
Interested in Contact Lenses? Yes☐No☐**(Please note that there is an additional fee for patients electing contact lenses for the contact lenses fitting or evaluation portion of the eye exam. Contact lenses evaluations are required annually. Your insurance may not cover such evaluation)**	
Are interested in information about Lasik? Yes☐No☐	Do you work at computer or video terminal? Yes☐No☐

REASON(S) FOR TODAY'S VISIT
☐ *Distant Vision*☐*Near Vision* ☐*Double Vision*☐*Dry Eye*☐ *"Red Eye"*☐ *Light Sensitivity* ☐*Eyes burn, itchy or discharge*
☐*Pain (please rate):*☐*Other:*
Have you ever had any eye surgery? Yes☐ No☐ If YES, please explain:
Please list all medications (with dosages) you are currently using:
Please list your allergies:

Please turn this form over to finish filling it out

Do you have any of the medical concerns?			
	Yes	No	If YES, please explain:
Blood/Lymphatic (anemia, bleedings, leukemia)			
Cardiovascular (heart disease, high blood pressure, stroke, vascular disease)			
Constitutional (chronic fatigues, persistent fever, trauma)			
Eyes(cataract, dry eyes, foreign body, glaucoma, infection, inflammation, age related macular degeneration)			
Endocrine (diabetes, cholesterol problem, hormonal dysfunction)			
Gastrointestinal (heartburn, abdominal pain, diarrhea)			
Skin (acne, cysts, dermatitis, eczema, psoriasis, rosacea, ulcers)			
Musculoskeletal (joint pain, swollen joints, muscle weakness)			
Nervous system (headaches, numbness, multiple sclerosis, seizures)			
Respiratory (shortness of breath, wheezing)			
Do any medical or eye diseases run in your family? Yes☐No☐			If YES, please explain:

Would you like to be our friend on Facebook? ☐**Yes** ☐**No**

Would you like to follow us on Google+ ? ☐**Yes** ☐**No**

Would you like to receive emails about industry news and MVEC promotions and coupons? ☐**Yes** ☐**No**

You *will* receive e-mail reminders about your upcoming appointments and/or office hours changes.

If you came for a routine eye examination, an automatic appointment ("pre-appointment") will be scheduled for your yearly check up. How would you prefer to be contacted with a reminder?

☐ **Phone**

☐ **E-mail**

☐ **Do not pre-appoint**

I certify that the above information is correct and hereby authorize the release of medical information to my insurance company and/or my referring physician. I authorize to bill my insurance if the physician(s) are covered under my plan.

I understand that I will be responsible for all non-covered services or materials, co-payments, co-insurances and deductibles.

I hereby consent to treatment at his/her office and authorize such treatments, examinations, medications, and diagnostic procedures as ordered by attending doctor. I understand that payment is due at the time of service. A $25.00 fee will be charged for all returned checks.

SIGNATURE: **DATE:**