

# EYECARE REGISTRATION AND HISTORY

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2 INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me 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.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## 3 PHONE NUMBERS

Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Spouse's Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

## EYE HEALTH HISTORY

Physician's Name \_\_\_\_\_

Date of last visit \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

Name of doctor \_\_\_\_\_

Do you wear glasses?  Yes  No  
 All the time  Occasionally  
 Reading  Driving  TV

Do you wear contacts?  Yes  No  
 Type \_\_\_\_\_ Hours/Day \_\_\_\_\_

Describe any problems you have with your contacts \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision - Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision - Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No



# HEALTH HISTORY

Date of last visit \_\_\_\_\_

Physician's Name \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? _____	Number of children _____			
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use _____	Alcohol use _____			

## MEDICATIONS

List any medications you are currently taking, including eye drops:

\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to \_\_\_\_\_ for any services furnished to me by that provider.

Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Beneficiary, Guardian or Personal Representative

Relationship to Beneficiary



Melia Robertson, OD  
3715 WEST MAIN STREET  
RUSSELLVILLE, AR 72801  
479.280.1991  
Fax: 479.280.1993

---

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided the Notice of Privacy Practices ("Notice"/NPP) from Robertson Eye Center, PA:

- It tells me how Robertson Eye Center, PA will use my health information for the purposes of my treatments, payment for my treatment, and other health care operations.
- The Notice explains in more detail how my health information may be used and shared by Robertson Eye Center, PA.
- Robertson Eye Center, PA will also use and share my health information as required/permitted by law.
- I agree and accept/consent to everything listed in the Notice.

Patient's Name: \_\_\_\_\_  
(Please Print)

Patient's Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Please list the people you would like authorized to pick up materials or get information regarding you or your care at our office below.

---

---

---

---