SIMPSON EYE PATIENT REGISTRATION FORM

(Please Print)

HOW DID YOU HEAR ABOUT SIMPSON EYE (please check one box):

❑ Billboard	❑ Our Employee	❑ Employer	❑ Friend (Who):	❑ Insurance	❑ Internet/Web
❑ Hospital (which one) St. Joseph			❑ Emerg. Room (which one) St. Joseph		
❑ Medical Doctor	❑ Optometrist (Who):		❑ Relative (Who):		
❑ Newspaper	❑ Screening	❑ Sign-Drive By	❑ Sun City	❑ Work	❑ Yellow Pages

PATIENT INFORMATION

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Rev.	Patient's last name:	First:	Middle:	
Birth Date: / /	Age:	Sex: ❑ M ❑ F	Social Security Number: - -	
Street		City:	State:	Zip:
Home phone no.: ( ) ❑ Mark Preferred Contact Number		Mobile or other phone no.: ( ) ❑ Mark Preferred Contact Number		
Preferred Email Address:		Are you here at the request of legal counsel, or for examination related to a lawsuit or legal event? ❑ Yes ❑ No		
Employer:	Retired: ❑ Yes ❑ No	Occupation:	Work phone no.: ( )	
Employer address:		Is this exam a workers compensation claim? ❑ Yes ❑ No	Contact name:	
Insured's last name:	First:	Middle:	Relationship to Insured: Legal Guardian	
Insured's date of birth / /		Insured's work phone no.:	Insured's social security no.: - -	
Patient's spouse or Parent (if minor): Last:	First:	Middle:	Spouse's employer:	
Referring Physician: First name:		Last name:	❑ M.D. ❑ D.O. ❑ O.D.	
Primary Care Physician: First name:		Last name:	❑ M.D. ❑ D.O. ❑ O.D.	
Physician's Phone: ( )		Physician's Address:		
Other family members seen here:				

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no: ( )	Work phone no: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Simpson Eye Associates or my Insurance Company(s) to release any information required to process my claims. I authorize the release of any medical information necessary to process all claims and I authorize the release of information to my referring physician or primary care physician.

Patient /Guardian Signature *Date*

DILATION PATIENT INFORMATION

During the course of your examinations at Simpson Eye Associates, it is likely that your eyes will be dilated with medications. This process allows the ophthalmologist to see into the back of your eye(s). It is a necessary part of the process in order to provide a comprehensive examination. The dilation process is relatively pain-free. However the side effects include blurred near vision which can last several hours (4-6 hours). In children the dilation drops are a bit stronger and will last longer. If you believe that your ability to drive has been impaired we strongly recommend that you have a driver pick you up.

In the future please be aware that appointments with one our physicians will likely include dilation.

Patient/Guardian Signature *Date*

MEDICAL HISTORY

What eye problems are you presently experiencing?

List previous eye surgery or eye problems.

REVIEW OF SYSTEMS: Do you have problems in any of the following areas? If "yes", please explain.

Ears, Nose Throat, Mouth, Neck	❑ Yes ❑ No	
Heart, Blood Vessels (heart attack, **high blood pressure**)	❑ Yes ❑ No	
Constitutional (fever, weight loss)	❑ Yes ❑ No	
Respiratory, (asthma, cough)	❑ Yes ❑ No	
Stomach, Intestines (ulcers/gastritis)	❑ Yes ❑ No	
Genitals, Kidney, Bladder	❑ Yes ❑ No	
Psychiatric (anxiety/depression)	❑ Yes ❑ No	
Endocrine (**diabetes**, thyroid)	❑ Yes ❑ No	
Blood/Lymphnodes (bruising, heavy aspirin use, bleeding, swelling)	❑ Yes ❑ No	
Bones, Joints, Muscles (arthritis)	❑ Yes ❑ No	
Skin, Breast (rash, hives)	❑ Yes ❑ No	
Neurological systems (stroke)	❑ Yes ❑ No	
Allergic, immunologic, blood (Including HIV or Aids)	❑ Yes ❑ No	
Head (headaches, aneurysm)	❑ Yes ❑ No	
Liver, Spleen	❑ Yes ❑ No	
Other:		

PAST HISTORY: List any medications you take, dose, number to times per day:

1.	4.
2	5.
3.	6.

List any major illnesses and injuries you had in the past:

List any surgeries you have had in the past (i.e. tonsils, appendix):

List any hospitalizations with explanation of what they were for (except surgeries as listed above):

Do you have any allergies to any medications? ❑ Yes ❑ No, If "yes" list medications:

SOCIAL HISTORY

Marital Status:	❑ Single	❑ Married	❑ Divorced	❑ Widowed ❑ Other
Do you smoke or use tobacco?	❑ Cigarettes –pks./days	❑ Chew - #/day	❑ Pipe - #/day	❑ Cigars - #/day
Do you drink alcohol?	Number of drinks per day		Number of drinks per week.	
Do you ever feel depressed?	❑ Yes ❑ No			

FAMILY HISTORY: Does your FAMILY have any of these problems? If "yes", indicate relationship to patient:

Crossed or wandering eye(s)	❑ Yes ❑ No		Cancer	❑ Yes ❑ No	
Blindness	❑ Yes ❑ No		Diabetes	❑ Yes ❑ No	
Corneal Disease	❑ Yes ❑ No		Heart Attacks	❑ Yes ❑ No	
Cataracts	❑ Yes ❑ No		High Blood Pressure	❑ Yes ❑ No	
Glaucoma	❑ Yes ❑ No		Kidney Disease	❑ Yes ❑ No	
Macular Degeneration	❑ Yes ❑ No		Stroke	❑ Yes ❑ No	
Retinal Detachment	❑ Yes ❑ No		Thyroid Disease	❑ Yes ❑ No	
Arthritis	❑ Yes ❑ No		Other		

What was the cause of death of your parents, siblings or children?

PHYSICIAN REVIEW OF HISTORY
