Sugar Creek Eyecare

EYECARE REGISTRATION AND HISTORY

Welcome to our office!

1 PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Married ❑ Widowed ❑ Single ❑ Minor

❑ Separated ❑ Divorced

Occupation _____

Patient Employer/School _____

Employer/School Phone ( ) _____

Spouse/Parent/Guardian Name _____

Spouse's Employer _____

Whom may we thank for referring you?

_____

2 INSURANCE

Please provide insurance cards for the receptionist to copy.

3 PHONE NUMBERS

Home ( ) _____ Cell ( ) _____

Work ( ) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Not living with you)

Name _____

Relationship _____

Home ( ) _____ Cell ( ) _____

Work ( ) _____ Ext. _____

4 MEDICATIONS

List any medications you are currently taking, including eye drops:
If you have a list, please give it to the receptionist to make a copy.

_____

_____

_____

Pharmacy Name _____

Phone ( ) _____

5

Are you pregnant? ❑ Yes ❑ No

Tobacco Use _____ Alcohol Use _____

Number of Children _____

List your medication or substance allergies: _____

_____

_____

6 HEALTH HISTORY

Primary Care Doctor _____ Phone ( ) _____

Please circle if you have had any of the following conditions:

AIDS/HIV	Emphysema	High Blood Pressure	Retinal Disease
Arthritis	Epilepsy	Kidney Disease	Rheumatic Fever
Asthma	Eye Surgery	Lazy Eye	Shingles
Blindness	Glaucoma	Lupus	Skin Conditions
Cancer	Hay Fever	Migraine Headaches	Stroke
Cataracts	Heart Condition	Pacemaker	Thyroid Conditions
Diabetes	Hepatitis (Type _____)	Poor Color Vision	Turned Eye

5

HEALTH HISTORY *Cont.*

	Yourself	Family Member

	Yourself	Family Member
	_____	_____
	_____	_____

ALLERGIES

List your allergies to **medications** or other **substances**:

_____

_____

_____

_____

_____

_____

_____

_____