**** Please fill out this form and email to info@fromereye.com or print and bring it to your appointment ****

Fromer Eye Centers **REGISTRATION FORM**

Today's Date: _____

Last Name _____ First Name _____ MI _____

Mr. ____ Mrs. ____ Ms. ____ Dr. ____

Male ____ Female ____

Race: [ ] African American [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native American [ ] Other _____

Date of Birth _____ Age _____

Ethnicity: _____

Primary Language: _____

Social Security Number _____ E-Mail Address _____

Pharmacy Name: _____

Street Address _____

Pharmacy Address: _____

Apartment Number _____

Pharmacy Telephone: _____

City _____ State _____ Zip Code _____

Contact Preference for Healthcare Reminders: ☐ Phone ☐ E-Mail

Primary Phone _____ Secondary Phone _____

Occupation/Employer _____ Work Phone Number _____

Primary Care Physician's Name (PCP) (REQUIRED) _____

PCP's Address _____ PCP's Telephone Number _____

Referring Physician: _____ _____ _____

First Name *Last Name* *Address/ Telephone Number*

In case of an emergency, please contact:

Name of Person _____ Relationship to you _____

Contact's Primary Phone _____ Contact's Secondary Phone _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Fromer Eye Centers or insurance company to release any information required to process my claims. Payment is expected at the time of the visit unless we participate with your insurance plan. Any copayment required under your plan is due at time of visit. I have received the Notice of Privacy Practices and I have had an opportunity to review it, and take a copy for my records.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

Fromer Eye Centers **PATIENT HISTORY QUESTIONNAIRE**

Account Number: _____

Patient Name: _____ Today's Date: _____

Who referred you to our practice? _____

What is the reason for today's eye exam? _____

_____

When was your most recent eye exam? _____

Are you interested in Laser Vision Correction? ___ Yes ___ No

Do you currently wear prescription glasses? ___ Yes ___ No

If Yes, do you need a stronger prescription? ___ Yes ___ No

How old are your glasses? _____

What do you use your glasses for (i.e work, computer, reading)? _____

Would you be interested in a new pair of glasses? _____

Do you currently take any eye drops? If so:

Eye drops	Right Eye	Left Eye

Medications: (Ex: pills, insulin, etc)

Do you have any allergies to medications?

_____

Other Allergies:

_____

Has a Family Member Had or Has the following?

	YES	or	No	Who
Blindness				
Cataracts				
Corneal Problems				
Crossed Eyes				
Diabetes				
Eye Surgery				
Glaucoma				
Heart Attack				
Retinal Disease				
Trauma to eyes				
Uveitis				

Social History:

Do you or did you smoke? _____

Packs per day _____

Do you, or did you drink Alcohol? _____

Drinks per Day _____

Are you pregnant? _____

Do you wear Contact Lenses? _____

Which Brand? _____

Have You noticed the following?

	YES	or	NO
Blurred Vision			
Discharge			
Dryness			
Eye Pain			
Itching			
Redness			

Have you had or Have?

	YES	or	NO
Anxiety			
Arthritis			
Blood Disorder			
Cancer			
Cataracts			
Depression			
Diabetes			
Dry Mouth			
Eye Surgery			
Gastrointestinal			
Glaucoma			
Heart Attack			
Heart Disease			
High Blood Pressure			
HIV/AIDS			
Hepatitis A,B,C			
Kidney Disease			
Lung Disease			
Lupus			
Retinal Disease			
Skin Rash			
Stroke			
Surgeries			
Thyroid Disease			
Trauma to Eyes			
Uveitis			