Internal Use Only √ In by: ________
Ins Card Needed: X- Yes
Recall Done / √ Out: ___________

Patient Registration and Health History

Last Name:______________________________**First Name**:_____________________________**MI**:______ **Date**: _____________

Preferred Name/Nick Name:__________________________________ **Title**: Dr Mr Mrs Miss Other__________

Sex: Male/Female **Birthdate**: _____________________ **Age**:__________ **Last 4 SSN**: ____________

Mailing Address: __________________________________ **City**: _______________ **State**: __________ **Zip**: _________

Home Phone: (_______)_____________ **Work**:(_______)_______________X:______ **Cell**:(_______)_____________________

Email Address: ____ **Preferred phone**: Home ph / Work ph / Cell ph

Marital Status: Married / Single / Widowed / Other **Partners Name**: _______________________________

Preferred Language: English / Spanish / Other ______________________ **Height** _________ **Weight**________________

Race: Am Indian / Asian / Black or African Am / Hispanic / White / Other ______________ **Ethnicity**: Hispanic / Non Hispanic

Employer: ____**Occupation**: ____

Employment: Full Time / Part Time / Retired / Unemployed / Other **Student**: Full Time / Part Time **Level**:________________

Insurance Company(ies)______________________________________ ***(Please present your card(s) so we can make a copy)***

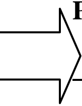
Who is responsible for outstanding charges on this Account (copays, etc)? Self / Other (fill in information below ***if other)***

Name: ____ **Relationship**: ________________ **DOB**: ______________

Address: ____ **City**: ______________ **State**:______ **Zip**: ______________

Notice of Privacy Practice

I authorize the release of any medical or other information necessary to process insurance. I authorize payment of benefits to Robeson Family Vision Center. I understand that if services and /or materials are not covered I will be responsible for charges incurred.
I understand that there will be finance charges on all past due accounts over 30 days.
I acknowledge that I have had the opportunity to review and have been offered a copy of **Robeson Family Vision Center's Notice of Privacy Practice**.



____ ____

Signature of patient or responsible party **Date**

Reason for today's exam? _____________________________Referred here by:____

Are you planning to get new glasses today? Yes / No Last Exam: ____/____/____ Examining Dr/Facility: _________________

Do you ***currently*** have any problems in the following areas?								
Loss of Vision	Y	N	Dryness	Y	N	Tired Eyes	Y	N
Blurred Vision	Y	N	Mucous Discharge	Y	N	Drooping Eyelid	Y	N
Fluctuating Vision	Y	N	Sandy or Gritty Feeling	Y	N	Crossed Eye/Lazy	Y	N
Night Vision Troubles	Y	N	Itching	Y	N	Contact Discomfort	Y	N
Glare/Light Sensitivity	Y	N	Burning	Y	N	Headaches	Y	N
Loss of Side Vision	Y	N	Excess Tearing	Y	N	See Floaters/Spots	Y	N
Double Vision	Y	N	Foreign Body Sensation	Y	N	See Flashing Light	Y	N
Infection of Eye	Y	N						

Have you ever been diagnosed with the following:

Cataracts: **YES / NO** *When*? ________Glaucoma: **YES / NO** *When*?________ Macular Degeneration? **YES / NO** *When*?_________

Do you wear contact lenses? **YES / NO** *Type*?:_____________ *If No, Are you interested in wearing contact lenses*? **YES / NO**

Does your vision limit any activities of daily living (driving, reading, sports, computer, work etc,)? **YES** **NO**

Would you like more information about any of the following: *UV eye damage?* **YES / NO** *Macular degeneration*? **YES / NO**

Cataracts? **YES / NO** *Glaucoma*? **YES / NO** *LASIK/Refractive Surgery*: **YES / NO**

List any **MEDICATIONS** you currently take (Rx and over-the-counter)____

Do you have **ALLERGIES** to any medications or other allergies (i.e. outdoor, bees etc) ? **YES / NO** *Please list*:_______________

List all **Major Illnesses**: (diabetes, high blood pressure, heart attack, stroke, etc): ____

Do you *currently* have any problems in the following areas?					
General/Constitutional (fever, heat stroke, weight loss/gain)	Y	N	**Muscles, bones, joints** (joint pain, stiffness, swelling,, cramps, arthritis etc)	Y	N
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, cough, dry mouth)	Y	N	**Skin** (pimples, warts, growths, rash etc)	Y	N
Cardiovascular (high BP, racing pulse etc)	Y	N	**Neurological** (numbness, headaches, seizures, paralysis, etc)	Y	N
Respiratory (congestion, wheezing, short of breath, emphysema etc)	Y	N	**Psychiatric** (anxiety, depression, insomnia etc)	Y	N
Gastrointestional (stomach upset, diarrhea, constipation, ulcers, hernia etc)	Y	N	**Endocrine** (diabetes, hypothyroid etc)	Y	N
Genital, kidney, bladder (frequent/painful urination, jaundice, etc)	Y	N	**Blood Lymph** (bleeding, high cholesterol, anemia, etc)	Y	N
Females Are you pregnant? Nursing? Or Taking Birth Control?	Y	N	**Allergic/Immunologic** (sneezing, redness, itching, hives, lupus etc)	Y	N

Has any member of your IMMEDIATE family (Father (F), Mother (M), Brother (B), Sister (S) had the following diseases:

Diabetes:______ **Hypertension:**______ **Thyroid:**______ **Cataract:**_______ **Glaucoma:** _______ **Macular Degeneration:** _____

Stroke:_____ **Blindness:**_____ **Other heritable disease**: ____

Do you drink alcohol? **YES / NO** *How much*? ____________

Do you use ANY tobacco products? **YES / NO** *How much*?_________ *How many years*? ________

Robeson Family Vision Center has invested in new software that allows us to further streamline our contact with you.

Our system sends EMAILS and/or TEXT MESSAGES for the following:

- **Appointment Confirmation**
- **Notification of glasses/contacts received**
- **Recall (due back for an exam/appointment)**
- **Campaigns (newsletters/sales)**

If you do not wish to receive text message or email notifications please VERBALLY notify a staff member so we may modify your file

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Release of Protected Health Information

In signing this authorization to release my protected health information, I acknowledge that I understand my right to medical information confidentiality and authorize Robeson Family Vision Center to discuss all my medical health information with the individual(s) listed below:

Name________________________________ Relationship__________________

Name________________________________ Relationship__________________

☐ I do not wish to share any of my information with any other individuals

____

Signature of patient or guarantor Date

Vision Source

Robeson Family Vision Center

EyeScreen Photo Examination

Robeson Family Vision Center is pleased to provide our patients with an advanced digital retinal exam called EyeScreen. EyeScreen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the EyeScreen exam to document your retinal image for our charts, screen for eye diseases and improve our ability to view your internal retinal health at a much higher resolution than a conventional slit lamp or ophthalmoscope.

The Doctors at Robeson Family Vision Center are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally many symptoms of systemic diseases such as diabetes, high blood pressure, other diseases and medication side effects can be detected with the EyeScreen Examination.

You can expect from this exam:

- An annual eye wellness EyeScreen photograph
- An in depth view of the retinal surface (where many eye diseases first manifest)
- The ability to review the images with you (we will show you your retina)
- A permanent record for your medical file, for serial analysis, comparisons, and diagnosis
- To be fast, easy and comfortable
- Usually no dilation drops for the test (They may be required for other purposes)

Since insurance will not pay for the EyeScreen Exam or any retinal image unless eye disease is present--the EyeScreen Examination is an out of pocket expense.

Our doctors and Robeson Family Vision Center staff recommend this procedure for all patients and will perform the EyeScreen Exam at an additional cost of $34.00 to the basic eye exam you are receiving today.

Please select one of the following boxes.

☐ **I AGREE TO** have my retinal health evaluated with the EyeScreen Exam.

☐ **I DO NOT** wish to have the Retinal Photographic Exam.

____

Patient Printed Name | Patient/Guardian Signature | Date

Actual Size

This Nerve head can be viewed larger than the computer screen w/ EyeScreen