



*Welcome
To Our
Office*

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ M.I.: _____ DOB: ____/____/____

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____ SSN: _____

Parent or Guardian (if Patient is a Minor): _____

Home Phone: (____) _____ Cell: (____) _____

Gender: M F **Marital Status:** Single Married Other

Hobbies: _____

How did you hear about our practice? _____

Employer Information

Employer's Name: _____ Work Phone: (____) _____

Insurance Information

Plan Name: _____ ID#: _____

Insured Name: _____ Relationship to Patient: Spouse Parent Other

Main Insured DOB: ____/____/____ Main Insured SSN: ____/____/____

Please provide your insurance card/information to Reception.

Emergency Information

Emergency Contact: _____ Relationship: _____

Contact's Home Phone: (____) _____ Contact's Work Phone: (____) _____

General Information

What is the reason for today's exam? _____

Is your reason for today's visit related to: Employment Accident _____

Do you experience frequent headaches? Yes No If yes, how often? _____

Date of Last Eye Exam? ____/____/____ By Dr. _____

Do you currently wear glasses or contact? ____All the time ____Occasionally ____No

Do you wear them for? ____Reading ____TV ____Computer ____Driving

Contact Lens Information

Do you wear contact lenses now? Yes No If yes, what type? _____

If no, are you interested in wearing contact lenses? Yes No

What is the name of the solution you are currently using? _____

How often do you throw your contact lenses away? _____

How long do you wear your contact lenses in a day? _____

Do you sleep in your contact lenses? Yes No If yes, how often? _____

Medical History

Name of Family Physician? _____ Phone: (_____) _____

Are you currently taking any medications (prescription or over the counter) including eye drops? If yes, please list.

Are you allergic to any medications? Yes No If yes, please list? _____

Personal and Family History

Do you or any of your blood relatives (i.e, grandparents, parents, brother or sister) have any of these conditions:

Ocular

Amblyopia _____

Glaucoma _____

Severe Hyperopia _____

Cataract _____

Macular Degeneration _____

Severe Myopia _____

Strabismus _____

Medical

Diabetes _____

Heart Disease _____

Asthma _____

High Blood Pressure _____

Thyroid Problems _____

Cancer _____

Social History

Do you drink alcohol? Yes No If yes, amount? _____

Do you use tobacco products? Yes No If yes, type/amount? _____

This office does accept certain insurance policies as a courtesy to our patients. However; 1) Insurance is for your benefit, not the doctor's. Just because you have insurance, does not mean that all services you receive in this office will be covered. Any uncovered services will be your responsibility; 2) You must pay all your deductibles and co-payments in full.

By signing below, you agree to the above terms. This signature will also allow assignment of all insurance payments to Dr. Joslin, and the release of any medical information necessary to pay your claim.

Patient's Signature: _____ Date: _____