Associate Ophthalmologists Registration Sheet

NAME :_____ MARITAL STATUS : [ ] S M D W GENDER : M F

ADD :_____APT :_____ CITY :_____ STATE :_____ ZIP :_____

DOB :_____ AGE :_____ SSN : _____ EMAIL :_____ _____

WORK :_____ HOME :_____ CELLULAR :_____

EMPLOYER :_____ OCCUPATION :_____

EMERGENCY : _____ REL : _____PHONE :_____

MEDICAL INFORMATION

GLASSES ? [ ] Y N CONTACTS ? [ ] Y N

GLAUCOMA ? [ ] Y N ?_____

DIABETES ? _____ HIGH BLOOD PRESSURE ? _____

OTHER ? _____

EYE PROBLEM ? _____

ALLERGIES ? _____

CURRENT MEDICATIONS :_____ _____

PREGNANT ? [ ] Y N PRIMARY CARE PHYSICIAN ? Y N

NAME :_____ PHONE :_____

REFERRED ?_____

HEALTH FAIR ? [ ] Y N :_____

WORK-RELATED INJURY ? Y N NOTIFIED? ? Y N

INSURANCE INFORMATION

INSURANCE :_____ SECONDARY [ ) _____

SUBSCRIBER IF OTHER THAN PATIENT [ ] SPOUSE PARENT OTHER

NAME [ ):_____ DOB :_____ SS# : _____

PLEASE READ AND SIGN BELOW

(_____)

(,)

( )

I authorize payment of medical benefits to