## EYECARE PEGISTRATION AND HISTORY

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Patient SS#		Relations	hip to Pat	tient		
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Employer Phone		with		a	nd assign d	irectly t
Spouse's Name				all insur-		
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Occupation				all information necessary to secue use of this signature on all insu		
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NameHome PhoneEYE HEALTH	Rela Work	tionship_ k Phone_	1. 9/63 1. 9/63	ou have had any of the follow	766 786	□ No
N CASE OF EMERGENCY, CONTACT (S Name	Rela  Work  HISTORY  Place a mark on "Yes" or " Bloodshot Eyes Blurred Vision – Distance	tionship_ k Phone_ "No" to in	dicate if y	ou have had any of the follow Floaters or Spots Glaucoma	wing:	
Name	Rela  Work  HISTORY  Place a mark on "Yes" or " Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near	tionship_ k Phone_ "No" to in	dicate if y	ou have had any of the follow Floaters or Spots Glaucoma Headaches	wing:  Yes Yes Yes	☐ No
N CASE OF EMERGENCY, CONTACT (SName	Rela  Work  HISTORY  Place a mark on "Yes" or " Bloodshot Eyes Blurred Vision – Distance	tionship_ k Phone_ "No" to in	dicate if y	ou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes	wing:  Yes Yes Yes Yes Yes	No
N CASE OF EMERGENCY, CONTACT (SName	Place a mark on "Yes" or Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor	"No" to in  Yes Yes Yes Yes Yes Yes	dicate if y No No No No No No	ou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision	wing:  Yes Yes Yes	
N CASE OF EMERGENCY, CONTACT (SName	Place a mark on "Yes" or " Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes	"No" to in Yes Yes Yes Yes Yes Yes	dicate if y No No No No No No No	rou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches	wing:  Yes Yes Yes Yes Yes Yes Yes Yes	
N CASE OF EMERGENCY, CONTACT (SName	Place a mark on "Yes" or " Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes Discharge from Eyes	"No" to in Yes Yes Yes Yes Yes Yes	dicate if y No No No No No No No	rou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches Night Vision, Poor	wing:  Yes Yes Yes Yes Yes Yes Yes Yes Yes	
Name	Place a mark on "Yes" or "Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes Discharge from Eyes Dizzy Spells	"No" to in  "Yes  Yes  Yes  Yes  Yes  Yes  Yes  Ye	dicate if y  No No No No No No No No No	rou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches Night Vision, Poor Red Eyes	wing:  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	No
Name	Place a mark on "Yes" or "Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes Discharge from Eyes Dizzy Spells Double Vision	"No" to in Yes Yes Yes Yes Yes Yes	dicate if y No	ou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches Night Vision, Poor Red Eyes Seeing Halos	wing:  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	No
Name	Place a mark on "Yes" or "Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes Discharge from Eyes Dizzy Spells	"No" to in  "Yes  Yes  Yes  Yes  Yes  Yes  Yes  Ye	dicate if y  No No No No No No No No No	ou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches Night Vision, Poor Red Eyes Seeing Halos Seeing Flashes	wing:  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	
Name	Place a mark on "Yes" or "Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes Discharge from Eyes Dizzy Spells Double Vision Dry Eyes Eye Infection Eye Injury	"No" to in Yes	dicate if y No	ou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches Night Vision, Poor Red Eyes Seeing Halos	wing:  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	
Name	Place a mark on "Yes" or "Bloodshot Eyes Blurred Vision – Distance Blurred Vision – Near Burning Eyes Cataracts Color Vision, Poor Crossed Eyes Discharge from Eyes Dizzy Spells Double Vision Dry Eyes Eye Infection	"No" to in  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	dicate if y No	ou have had any of the follow Floaters or Spots Glaucoma Headaches Itching Eyes Light Sensitive Loss of Vision Migraine Headaches Night Vision, Poor Red Eyes Seeing Halos Seeing Flashes Temporary Loss of Vision	wing:  Yes Yes Yes Yes Yes Yes Yes Yes Yes Ye	

Primary Care Physician's N	Vame		Phone	Date of last of	in the
		ou hour had any of the	- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Date of last v	
any of the following problem	ems.  Yourself	Family Members	following. Also place a mai		
AIDC # III	Table Services	Caronida and selection		Yourself	Family Member
AIDS/HIV	Yes No	☐ Yes ☐ No	Hepatitis (Type	_)	Yes No
Arthritis	☐ Yes ☐ No	Yes No	High Blood Pressure	Yes No	Yes No
Artificial Heart Valve	Yes No	Yes No	Kidney Disease	Yes No	Yes No
Artificial Joints	☐ Yes ☐ No	☐ Yes ☐ No	Lazy Eye	Yes No	☐ Yes ☐ No
sthma	Yes No	Yes No	Lupus	☐ Yes ☐ No	Yes No
Bleeding	Yes No	Yes No	Migraine Headaches	Yes No	☐ Yes ☐ No
Blindness	Yes No	Yes No	Pacemaker	Yes No	Yes No
Cancer	Yes No	Yes No	Poor Color Vision	☐ Yes ☐ No	Yes No
Cholesterol (High)	☐ Yes ☐ No	☐ Yes ☐ No	Retinal Disease	☐ Yes ☐ No	Yes No
Chemical Dependency	Yes No	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	☐ Yes ☐ No
iabetes	☐ Yes ☐ No	Yes No	Shingles	☐ Yes ☐ No	☐ Yes ☐ No
rug Sensitivity	Yes No	Yes No	Skin Conditions	☐ Yes ☐ No	☐ Yes ☐ No
mphysema	Yes No	☐ Yes ☐ No	Stroke	Yes No	
pilepsy	Yes No	☐ Yes ☐ No	Thyroid Conditions	Yes No	☐ Yes ☐ No
ye Surgery	Yes No	☐ Yes ☐ No	Tuberculosis	Yes No	
laucoma	☐ Yes ☐ No	☐ Yes ☐ No	Turned Eye		☐ Yes ☐ No
lay Fever	☐ Yes ☐ No	☐ Yes ☐ No	Are you pregnant?		∐ Yes ∐ No
eart Condition	☐ Yes ☐ No	Yes No	Tobacco use	Number of c	niidren
			Tobacco use	Alcohol use	
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MED	ICATIONS		AL	LERGIES	
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