WESTERN WAKE EYE CENTER, P.A.
PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME_____ SS#_____
LAST M.I. FIRST

ADDRESS_____ DOB_____

CITY_____STATE_____ZIP_____ AGE_____

HOME PHONE_____CELL_____WORK_____

MALE ____ FEMALE _____ MARITAL STATUS_____

EMPLOYER'S NAME_____
ADDRESS_____

TODAY'S VISIT _____MEDICAL _____ROUTINE_____CONTACTS_____GLASSES

INSURANCE CARDHOLDER INFORMATION

NAME_____SS#_____DOB_____

EMPLOYER NAME _____

ADDRESS_____

TYPE OF COVERAGE: HEALTH___MEDICARE___WORKER'COMP___ROUTINE___

MEDICAL HISTORY- PLEASE PRINT AND ANWER ALL QUESTIONS

NAME OF FAMILY/MEDICAL DOCTOR_____
REFERRED BY_____

PLEASE CHECK ANY THAT APPLY:

___GLASSES ___EYE INJURY ___FAMILY HISTORY OF GLAUCOMA
___CONTACTS ___EYE OPERATION ___FAMILY HISTORY OF CATARACTS
___DIABETES ___KIDNEY TROUBLE ___FAMILY BLIND OR NEARLY BLIND
___HIGH BLOOD PRESSURE
___LIST CHRONIC OR SERIOUS ILLNESS_____

ARE YOU ALLERGIC TO ANY MEDICATIONS?
IF YES, PLEASE LIST_____

LIST MEDICATION YOU ARE TAKING NOW OR IN PAST YEAR.
NAME AND PURPOSE OF EACH

_____ _____ _____

_____ _____ _____

Authorization to pay benefits: I hereby authorize payment of medical benefits to WESTERN WAKE EYE CENTER, P.A.

_____ _____
SIGNATURE **DATE**