REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION

Patient's Name (First name Middle name Last name):				☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
Email Address:	Date of Birth:		Age:	Sex: M F
Street address:	Home phone no.: ( )		Cell phone no.: ( )	
City:	State:		Zip:	
Occupation:	Employer:		Employer phone no.: ( )	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

Name (First name Middle name Last name):	Date of Birth:		Sex: M F
Street address:	City:	State:	ZIP Code:
Relationship to Patient:	Home phone no.: ( )	Cell phone no.: ( )	

INSURANCE INFORMATION

Name of **PRIMARY** Insurance, **ID#**& **Subscriber if different from self:**	Name of **SECONDARY** Insurance , **ID#**& **Subscriber if different from self:**

Primary Care Physician (PCP)

Name:	Address:	Phone no.: ( )

Referring Doctor (Other than Primary Care Physician & Optometrist)

Name:	Address:	Phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

ARE YOU INTERESTED IN? (please check **ALL** appropriate boxes)

☐ Decreasing Your Need for Reading Glasses	☐ LASIK	☐ Cosmetic Options: Botox, Dermal Fillers, Eyelid Lifts, Etc

PHARMACY

Name:			
Address:	City:	State:	Zip:
Phone #:	Fax #:		

Patient Signature:______________________________ Date:____________________

Patient Name: **Date of Birth:** **Date:**

Reason(s) for today's visit:

Who is your Primary Care Physician (PCP)?

Do you currently see any other doctor/specialist for other medical conditions? Yes / No

Past Medical History

List any medical condition(s) you have:
____
____

List any hospitalizations and/or surgeries with date(s):
____
____

List any EYE surgery with date(s):
____
____

List your prescribed medication(s), including vitamins/supplements: o No Current Meds
____
____

List known allergies (including medication allergies) and reaction: o None Known Allergies (NKA)
____

Have you ever had a reaction to anesthesia? o Yes o No

Social History

Do you use tobacco? o Yes o No **Year Quit, if applicable**:

Do you consume alcohol? o Yes o No **Drinks per week:**

What is your occupation?

Family History

Do you have relatives with:
o Blindness o Cataract(s) o Glaucoma o Diabetes oHypertension o Heart Disease o Stroke
o Cancer oThyroid Disease o Arthritis o Other ______________________ o Unknown

.

833-509-OCLI
(833-509-6254)

OCLI VISION

ocli.net

Patient Name: **Date of Birth:** **Date:**

Are you currently experiencing any of the following? If yes, circle:	YES	NO	
GENERAL/CONSTITUTIONAL: fever, heatstroke, weight loss, weight gain, fatigue, other			Review of Systems
EYES: blurry vision, dry eyes, floaters, light sensitivity, discharge, pain, other			
EAR, NOSE, THROAT: hard of hearing, congestion, earache, cough, dry mouth, other			
CARDIOVASCULAR: pacemaker, defibrillator, high or low blood pressure, racing pulse, other			
RESPIRATORY: congestion, wheezing, short of breath, other			
GASTROINTESTINAL: stomach upset, diarrhea, constipation, hernia, ulcers, other			
GENITOURINARY: painful/frequent urination, kidney disease, prostate problems, other			
FEMALES: pregnant, nursing			
MUSCULOSKELETAL: joint pain, stiffness, swelling, cramps, arthritis, other			
SKIN: pimples, warts, growths, rash, other			
NEUROLOGICAL: numbness, headache, seizure, paralysis, loss of consciousness, other			
ALLERGIC/IMMUNOLOGIC: redness, itching, hives, Lupus, Sjogren's, other			
PSYCHIATRIC: anxiety, depression, insomnia, other			
BLOOD/LYMPH: bleeding, cholesterolemia, anemia, problems with blood transfusion, other			
CANCER:			
ENDOCRINE: Type I Diabetes, Type II Diabetes, hypothyroid, other ☐ Insulin ☐ Non-Insulin Last blood sugar level Date taken			

Do you wear glasses for distance? o Yes o No **Do you wear reading glasses?** o Yes o No

Do you wear contact lenses? o Yes o No

(Type) _______________ **Contact Lens Wear for** ____ **years** **Dispose of every** ____ **days/weeks/month**

Patient Signature: ____ **Date:** ____________ **Doctor Initials:** ______