**New Patient Registration Form**

First Name: Middle Initial: Last Name:

Preferred Name: Date of Birth: SSN:

Address: Apt/Unit:

City: State: Zip Code:

Is the above address the same as your mailing address? Yes [ ]  No [ ]

If no, please include mailing address:

Primary Phone (**required**): This is my: Home [ ]  Work [ ]  Cell [ ]

Secondary Phone: This is my: Home [ ]  Work [ ]  Cell [ ]

Email address (**required**):

Do you prefer that we contact you via phone/text or email? Phone: [ ]  Email: [ ]

Do you consent to receiving electronic notifications from Smart Eye Care about appointment scheduling, billing, and/or clinic events and inclement weather closures? Yes [ ]  No [ ]

PCP/Primary Doctor:

Date of last physical:

Medical Insurance: Vision Insurance

Other Insurance:

Guarantor, guardian, or spouse name:

Who is authorized to access your account and health information?

This is a person with whom SEC staff may discuss and disseminate information about services, account balances, and other aspects of your protected health information. **If this person’s account should be linked to your account, please check here**: [ ]

Current Employer:

Occupation:

|  |
| --- |
| **Medical History** |
| Are you/have you in the past experienced problems with any of the following? | If checked please specify |
| Ear, Nose, Throat | [ ]  |  |
| Blood/Lymph  | [ ]  |  |
| Genital, Kidney, or Bladder | [ ]  |  |
| Cardiovascular | [ ]  |  |
| Respiratory | [ ]  |  |
| Gastrointestinal | [ ]  |  |
| Endocrine | [ ]  |  |
| Neurological | [ ]  |  |
| Psychiatric | [ ]  |  |
| Muscular/Skeletal | [ ]  |  |
| Other | [ ]  |  |
| If other, please explain:  |
| **Family History** |
| Has anyone in your family experienced problems with the following? | Relationship  | If checked please specify |
| Ear, Nose, Throat | [ ]  |  |  |
| Blood/Lymph  | [ ]  |  |  |
| Genital, Kidney, or Bladder | [ ]  |  |  |
| Cardiovascular | [ ]  |  |  |
| Respiratory | [ ]  |  |  |
| Gastrointestinal | [ ]  |  |  |
| Endocrine | [ ]  |  |  |
| Neurological | [ ]  |  |  |
| Psychiatric | [ ]  |  |  |
| Muscular | [ ]  |  |  |
| Eyes | [ ]  |  |  |
| Other | [ ]  |  |  |
| If other, please explain:  |
| **Eye History** |
| Are you/have you in the past experienced or been diagnosed with any of the following? | If checked please specify |
| Glaucoma | [ ]  |  |
| High blood pressure | [ ]  |  |
| Macular degeneration | [ ]  |  |
| Cataracts | [ ]  |  |
| Color blindness | [ ]  |  |
| Lazy eye or crossed eyes | [ ]  |  |
| Eye or eyelid infections | [ ]  |  |
| Dryness, itching, sandy/gritty feeling | [ ]  |  |
| Blurry or double vision | [ ]  |  |
| Flashes or floaters | [ ]  |  |
| Eye surgery or eye injury | [ ]  |  |

Please list any current medications:

Please list any past surgeries:

Are you diabetic? Yes [ ]  No [ ]  Month/Year of Diagnosis

Last Blood Sugar: HbA1c:

Do you currently use tobacco products? Yes [ ]  No [ ]  Frequency:

Are you currently experiencing any eye health or vision problems not mentioned above? Yes [ ]  No [ ]

If yes, please specify:

Do you wear glasses or contacts? Glasses [ ]  Contacts [ ]  Neither [ ]

Signature: Date:

**You can fax your completed registration form to the appropriate clinic in advance, or bring it with you on the day of your visit.**

**If you wear glasses or contacts, please bring your current glasses, prescription sunglasses and/or contact lens boxes to your appointment, along with your current insurance ID cards.**