**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.**