PATIENT REGISTRATION FORM

Dr. Jeffrey Gold and staff would like to welcome you to our office. We need the following information about you and your family's history. This questionnaire will help the doctor provide you with a better eye health examination. All information is CONFIDENTIAL.

Mr. Mrs. Ms. Miss Date______________________

Name______________________ Birthdate______________ SS#______________

Address______________________ City/State______________ Zip__________

Home Ph#______________ Cell Ph#______________ Work Ph#______________

E-Mail______________________ Occupation______________________

Have you ever been examined here before? YES / NO When? ______________

Name of your last eye doctor or vision center.______________________

How many years since your last eye examination? **(circle) <1 1 2 3 4+**

How did you hear about our office?______________________

If one of our patient's referred you, please provide us with their name.

PRIMARY VISION INSURANCE

Insurance Name______________________ Policy / ID #______________

Subscriber______________________ Group#______________

Subscriber SS#______________________ Subscriber Birthdate______________

Subscriber relation to patient______________________

PRIMARY HEALTH INSURANCE (MAJOR MEDICAL)

Insurance Name______________________ Policy#______________

Subscriber______________________ Group#______________

FINANCIAL RESPONSIBILITY

I hereby authorize my insurance company to pay and hereby assign to Dr. Jeffrey Gold all benefits, if any, otherwise payable to me for all services. If for any reason my insurance does not cover all of the cost, or I am not insured for this claim, I will pay Dr. Jeffrey Gold, within 30 days of the billing date. In the event that I do not pay within 30 days I will pay all collection service fees (including attorney fees) and the legal rate of intrest on the indebtedness to Dr. Jeffrey Gold.

SIGNATURE______________________ DATE______________

PRINT NAME______________________

AMENDMENTS:	PATIENT INITIAL	CHANGES
DATE:_______	NO CHANGE	
DATE:_______	NO CHANGE	
DATE:_______	NO CHANGE	

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PLEASE TURN FORM OVER

REASON FOR TODAY'S VISIT (problems) ____________________

PERSONAL EYE HISTORY: CHECK ONLY THOSE THAT APPLY TO YOU.

	____ Glaucoma/Suspect	____ Macular Degeneration
____ Chronic Red Eyes	____ Lazy Eye	____ Uveitis / Iritis
____ Dry / Sandy Eyes	____ Wandering Eye Turn	____ Ocular allergies
____ Eye Pains	____ Colored Halos Around Lights	____ Floating Spots In Vision
____ Previous Eye Injury	____ Cataracts Or Cataract Surgery	____ Flashing Lights
____ Watery Eyes	____ Retinal Disorder	____ Other Eye Conditions Or Surgery
	____ Vision Therapy (Eye Patching)	____ None Of The Above

IS THERE A FAMILY HISTORY OF GLAUCOMA? YES NO

Is there a family history of any of the eye diseases mentioned above? If so please specify which disease and which family member. ____________________

CONTACT LENS INFORMATION

Do you wear contact lenses? YES NO **Are you interested in contact lenses today? YES NO**

What Type? ____ Disposable ____ Soft Daily Wear ____ Soft Extended Wear ____ Hard or Gas Permeable ____ Colored Contacts ____ Bifocal Contacts

Are you interested in LASER VISION CORRECTION? YES NO

PERSONAL MEDICAL HISTORY:

Name of your family physician ____________________ MD / DO Phone# __________

Address ____________________ Fax# __________

Years since you last medical exam: (circle) <1 1 2 3 4+

There are many medical problems and medications that can affect to your eyes. The following questions assist the doctor in detecting these sight-threatening problems.

CHECK THE ITEMS YOU HAVE OR HAVE HAD IN THE PAST.

____ Diabetes	____ Cancer	____ Chronic Skin Disease
____ Heart Disorder	____ Arthritis	____ Seasonal Allergies
____ High Blood Pressure	____ Thyroid Problems	____ Hearing Difficulties
____ Hardening of The Arteries	____ Respiratory / Asthma	____ Nervousness / Depression
____ Poor Circulation	____ Lupus	____ Chron's / IBS
____ Other Blood Disorders	____ Rheumatic Fever	____ Alcohol / Substance Abuse
____ Stroke	____ Epilepsy	____ Smoking: Packs Per Day ____
____ Cholesterol	____ Severe Headaches	____ Surgeries ____
____ HIV / TB / Hepatitis	____ Back Problems	____ Other Medical Problems ____
		____ None Of The Above

Do you have children? YES NO Ages: __________ Are you pregnant? YES NO Due date __________

Please list all medications that you are taking or should be taking, including any over the counter medications and birth control pills. ____________________

List any drug allergies that you may have: ____________________

AMENDMENTS: PATIENT INITIAL CHANGES

DATE: ____ NO CHANGE ____________________

DATE: ____ NO CHANGE ____________________

DATE: ____ NO CHANGE ____________________

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