Southside Center for Sight Patient Registration

Mr. Mrs. Ms. Dr.____
(Circle) First Name Middle Initial Last Name Nickname

Address ____
Street City State Zip

Primary Phone # ______________________ Second Phone#______________________

Third Telephone #________________ E-mail ______________________________

Date of Birth _______________ Sex: Male____Female____SSN#____________________

Employer _________________________________ Marital Status: ________________

Insurance Company: Primary___________________ Secondary __________________

Insurance Member Name:____
(If different than patient) Last First Middle Initial

Relationship to Patient ______________________________ SSN# ________________

Date of Birth ______________ Member Address _______________________________

Guarantor for Minor or POA _______________________Relationship________________

*Guarantor/POA Address:_________________________ Phone #________________

*Guarantor SSN#:____________________________Date of Birth:________________

Primary Care Physician: ____

Address ____

Referred By: ____

Emergency Contact: ______________________________Phone #________________

Nearest Relative Not Living with You ___________________ Phone #______________

List the person/s who may have access to my medical records:______________________

Are you currently in a Skilled Nursing Facility? Yes ________ No ___________

Name of Facility____

Facility Address _________________________________ Phone # _______________

Southside Center for Sight Medical Questionnaire

Account #____________ Date of Service________________

Name ____ **Date of Birth** ________________

PCP________________________________ **Optometrist** ______________________________

Referred by____

EYE PROBLEM / INJURY

____

____

____

____

EYE SURGERIES / DATES

____

____

EYE DROPS

____

____

____

GENERAL SURGERIES / DATES

____

____

____

____

ALLERGIES TO MEDS / ANESTHESIA

____

____

____

PHARMACY NAME / LOCATION

____

____

PLEASE ATTACH MEDICATION LIST

HISTORY OF (check all that apply)

□ Glaucoma □ Macular Degeneration □ Retinal Detachment □ Diabetes □ High Blood Pressure

□ Rheumatoid Arthritis/JRA □ Rosacea □ Sjogrens □ Thyroid Disease □ Histoplasmosis □ Shingles

□ Cancer □ Heart Disease □ ____

□ ____

FAMILY HISTORY OF (check all that apply)

□ Diabetes □ Glaucoma □ Cancer □ High Blood Pressure □ Macular Degeneration □ Retinal Disease

□ ____

Occupation ____

Hobbies ____

Do you: Smoke? Y/N ____PPD____Yrs Alcohol Soc ____/day Recreational Drug Use Y/N