Patient Name _____ Account #_____ Date of Service_____

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 # _____

Patient Name _____ Account #_____ Date of Service_____

Southside Center for Sight Medical Questionnaire

Name _____ Date of Birth _____

Primary Doctor _____

Referred by_____

REASON FOR TODAY'S VISIT_____

CURRENT MEDICAL PROBLEMS AND/OR HISTORY OF (check all that apply)

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

□ Rheumatoid Arthritis/JRA □ Rosacea □ Sjögrens/Dry Eye □ Thyroid Disease □ Histoplasmosis

□ Shingles □ Cancer □ Heart Disease □ _____

EYE SURGERIES DATE

1) _____

2) _____

3) _____

4) _____

GENERAL SURGERIES DATE

1) _____

2) _____

3) _____

4) _____

FAMILY HISTORY OF - Check all that apply and note which family member (i.e. Parent, Grandparent, Sibling, etc.)

□ Diabetes _____ □ Glaucoma _____ □ Cancer _____

□ High Blood Pressure _____ □ Macular Degeneration _____

□ Retinal Disease _____ □ _____ _____

SOCIAL HISTORY

Do you use tobacco products? _____ If yes, type / amount / how long? _____

_____

Do you drink? _____ If yes, how many _____ / how often _____

Patient Name _____ Account #_____ Date of Service_____

Pharmacy _____

Location and/or phone number _____

_____

ALLERGIES TO MEDICATIONS / ANESTHESIA - (Please note the allergen, as well as the reaction)

1)_____

2) _____

3) _____

LIST OF CURRENT MEDICATIONS / SUPPLEMENTS

Medication / Supplement (Brand and Generic Name)	Dose	Frequency	Reason for Taking