PATIENT REGISTRATION & MEDICAL HISTORY

Date_____

☐Mr.☐Mrs.☐Ms.☐Dr.☐Fr. ☐Sr. Last Name _____ First Name _____ MI ___
Address_____ City_____ Zip_____
Birth Date_____ SS#_____ Email Address_____
Home Phone_____ Work Phone_____ Cell Phone_____
Last Eye Exam Date_____ Occupation_____ Employer Name_____
Vision Insurance_____ Member ID#_____ Member Name_____
Medical Insurance_____ ID#_____ Primary Physician_____
Emergency Contact_____ Phone number_____

I consent to the receipt of my contact lens and/or spectacle prescription via email or paper at the end of the evaluation when prescription is finalized.

Patient/Guardian's Signature _____ Date _____

FOR RETURNING PATIENT ONLY:

☐ **I acknowledge that there is no change in my family, medical and social history and information for the following sections.**
Signature _____Date_____

FAMILY, MEDICAL AND SOCIAL HISTORY

Please check if you or which immediate family member **(please indicate)** have any of the following conditions:

☐ Check here if **none** apply

High Blood Pressure	☐self ☐family _____	Kidney Disease	☐self ☐family _____	Macular Degeneration	☐self ☐family _____
Heart Disease	☐self ☐family _____	Thyroid Disease	☐self ☐family _____	Retinal Detachment	☐self ☐family _____
High Cholesterol	☐self ☐family _____	Blindness	☐self ☐family _____	Eye Disease	☐self ☐family _____
Diabetes	☐self ☐family _____	Glaucoma	☐self ☐family _____	Allergies	☐self ☐family _____
Other Condition	☐self ☐family _____	Description	_____		

Do you have any **drug allergies**? ☐yes ☐no If yes, please list _____
Current **medications** _____
Please list any **eye conditions/injuries**, other major injuries, surgeries and/or hospitalizations you have had _____
_____

Are you **pregnant and/or nursing**? ☐yes ☐no

Do you use **tobacco products, drink alcohol or use illegal drugs**? ☐yes ☐no If yes, please explain what type/amount/how long:
_____

If someone referred you to our office, please provide a name so we can send them a thank you card _____

PERSONAL EYE INFORMATION

Are you interested in refractive surgery? ☐yes ☐no Do you experience problems with glare or reflection? ☐yes ☐no

Do you use computers at work? ☐yes ☐no If yes, how many hours a day? ____ Viewing distance to monitor ____ to keyboard ___

Do you wear contact lenses or glasses? ☐yes ☐no If yes, what type and how old is your current pair? _____

FOR NEW PATIENT ONLY:

Please read our office's HIPPA policy in the binder, if you would like a copy of Richard J. Chong, OD's Notice of Privacy Practices, please let our staff know.

Patient/Guardian's Signature _____ Date _____