Print Form

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Date _____

Registration Form

----------Patient Information----------

Legal First Name _____ M.I. _____ Last Name _____

SSN_____ Date of Birth_____ Age_____ Marital Status: _____

Mailing Address_____ City _____ State _____ Zip _____

Physical Address (if different than above)_____ City_____ State _____ Zip _____

Home Phone _____ Work # _____

Cell Phone# _____ E-Mail Address _____

Occupation _____ Employer _____

Emergency Contact Person: _____ Phone_____

Who may we thank for referring you to our practice _____

----------Responsible Party and Billing Information----------

Same As Above_____

First Name_____ M.I. _____ Last Name _____

Mailing Address_____ City _____ State _____ Zip _____

Home Phone _____ Work # _____ Cell # _____

Occupation _____ Employer _____

Relationship to Patient _____DOB _____SS# _____

----------Insurance Information----------

Primary Insurance Company _____ Secondary Insurance Company _____

I understand that I am responsible for my debt. If my insurance company has not paid within 45 days I am responsible to pay the debt.

I acknowledge that I am aware of and have been offered a copy of Grand Valley LASIK & Cataract's Notice of Privacy Practices.

Signature_____ Date_____

Medical History Questionnaire

Name _____ Date of Birth _____

Personal Eye Information

Date of last Eye Exam_____ Were your eyes dilated? _____ Y/N _____

Name of Eye Doctor_____

Have you ever had any eye injuries Y/N _____Type _____ Date _____

Have you ever had any eye surgeriesY/N _____ Type_____ Date_____

Do you have: **Glaucoma**? Y/N ____ **Cataracts**? Y/N ____ **Dry Eyes**? Y/N ____ **Blurred Vision**? Y/N _____

Other eye problems? _____

Do you wear glasses? Y/N _____ Contact lenses? Y/N_____ Type?_____

Family History

High blood pressure?Y/N ____ relation_____ Diabetes? Y/N ____ relation _____

Macular Degeneration? Y/N ____relation _____ __ Glaucoma? Y/N ____relation _____

Retinal Detachment? Y/N ____ _relation _____ Cataracts? Y/N ____relation _____

Other eye Conditions? Y/N _____ Relation _____

Other Health History

What is your general health? _____

Do <u>you</u> have any problems with any of these systems?

Nervous System? Y/N _____ Integementary? (skin) Y/N ____ Musculoskeletal? Y/N _____

Genitourinary? Y/N _____ Endocrine? (glands) Y/N _____ Allergic/Immunologic? Y/N ____

Gastrointestinal? Y/N _____ Blood/Lymph? Y/N _____ Mental? Y/N _____

Respiratory? Y/N _____ Ears/Nose/Throat? Y/N _____ Other_____

Have you had any surgeries Y/N _____Type and Dates _____

_____

_____

Diabetes? Y/N_____ Type _____ Date of Diagnosis _____

Allergies? Y/N ____ **To What**_____

Medication Allergies? Y/N _____ **Name of Medication/s Allergic to:**_____

_____

Current Medications (please list) _____

_____

Do you use Tobacco products? Y/N _____ frequency_____ Alcohol? Y/N _____

Other Substances? Y/N _____

Family Physician_____ Phone Number_____ Date of Last Visit_____