TACOMA EYE

Patient Registration Form

Patient Name:_____

Patient date of birth:_____

Patient SSN:_____

Address: _____City/State/Zip:_____

Phone number we can contact you_____

Name of parent/guardian completing form (if applicable):

_____

Email address we can contact you:_____

How did you hear about us? *(A friend, Social Media,Radio)*_____

Vision Plan:	**Medical Insurance:**	**Secondary Medical Insurance:**
Name of Vision Plan	Name of Med Insurance	Secondary Med Insurance
Policy ID#	Policy ID #	Policy ID #
Group #	Group #	Group #
Subscriber name:	Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB	Subscriber DOB
Subscriber SSN:	Subscriber SSN:	Subscriber SSN:
Relationship Between Patient & Subscriber:	Relationship Between Patient & Subscriber:	Relationship Between Patient & Subscriber:

Tacoma Eye Health Questionnaire

Please complete both sides of this questionnaire

Patient Name: _____	**Date of Birth:** _____
Reason for today's visit (circle one) I need eyeglasses I need contact lenses I want a check up. Other*(write below)*:	**Who is your Primary care provider (PCP)?** _____ **Please list any other provider caring for you** _____
Have you ever been diagnosed with any of the following eye conditions? (Circle if yes) Macular Degeneration Glaucoma Diabetic Retinopathy Dry Eye Iritis/Uveitis Retinal defects or degenerations	**Do you have any eye/vision concerns today? (Circle if yes)** Redness Burning Itching Tearing Blurred vision/Eyestrain
Family Medical History *Please CIRCLE if family members have:* *Cancer* *Diabetes* *High Blood pressure.* *Thyroid problems*	**Family Ocular History** *Please CIRCLE if family members have:* *Cataracts* *Macular degeneration* *Glaucoma*
What medication allergies do you have?	**PFSH Tobacco Smoking Status (Circle one)** I smoke I quit smoking I don't smoke
What medications are you currently taking? *(prescription and over-the counter)*	

Tacoma Eye Health Questionnaire

Please complete both sides of this questionnaire

Review Of Systems

Have you been treated for any of the following?

CONSTITUTIONAL

Developmental Issues

Cancer

Fatigue syndrome

ENT

Hearing loss

Sinusitis

Dry Mouth

NEUROLOGIC

Multiple Sclerosis

Epilepsy

Autism SD

PSYCHIATRIC

Depression

ADHD

Anxiety'Bipolar

CARDIOVASCULAR

High Blood pressure

Stroke

Heart disease

RESPIRATORY

Asthma

COPD

Sleep Apnea

Review of Systems

Have you been treated for any of the following?

GI

Crohn's Dz

Colitis

GU

Kidney Dz

STD

Pregnant or Nursing

MUSC/SKEL

Arthritis

Fibromyalgia

Ankylosing Spondylitis

INTEGUMENTARY

Eczema

Acnes Rosacea

Shingles

ENDOCRINE

Diabetes Type 1 or Type 2

Thyroid dysfunction

H&L

Anemia

High cholesterol

IMMUNE

Lupus

Sjogren's Syndrome

Other items not covered that you would like us to know about?

I attest this form was is completed by the signee to their best recollection and ability.

Signed:_____

Date:_____