OLD TOWN Optical

Patient Registration Information

Please complete the following information.

Legal Name:_____

Address:_____City:_____Zip Code:_____

Home Phone:_____Work/Cell Phone:_____

Email (to receive promotions special event invitations):_____

Age:_____ Date of Birth:_____Soc. Sec. # (Last Four):_____

Sex:_____ Occupation:_____Employer:_____

In Case Of Emergency, Please Contact:

Name:_____ Relationship:_____

Phone:_____

Guardian Information (If patient is under 18-years-old, or has a Power of Attorney)

Guardian Name:_____

Address:_____

Soc. Sec. # (Last Four):_____

Home Phone:_____Work Phone:_____

Insurance Information:

Name of Insured:_____Insured's Date of Birth:_____

Soc. Sec. # (Last Four):_____Relationship to Patient:_____

Primary Insurance Company:

Address:_____Phone:_____

Policy #:_____ Subscriber ID:_____

Patient History

Primary Care Physician:

Have you ever been treated for any medical conditions?

Yes:☐ No:☐ If yes, please explain:_____

Have you ever had an eye disease?

Yes:☐ No:☐ If yes, please explain:_____

Have you ever had surgery?

Yes:☐ No:☐ If yes, date & reason:_____

Have you ever been hospitalized?

Yes:☐ No:☐ If yes, date & reason:_____

Do you take any medications?

Yes:☐ No:☐ If yes, please list:_____

Do you take any eye medications?

Yes:☐ No:☐ If yes please list:_____

Do you have any food or drug allergies?

Yes:☐ No:☐ If yes please list:_____

Review of Systems (Do you currently have any of the following problems?):

Chronic fever, unexpected weight loss/gain, fatigue?

Yes:☐ No:☐ If yes, please explain:_____

Ear/nose/throat, hearing loss, sinus problems, sore throat?

Yes:☐ No:☐ If yes, please explain:_____

Heart problems, chest pains, irregular heart beat?

Yes:☐ No:☐ If yes, please explain:_____

Respiratory problems, short of breath, wheezing, coughing?

Yes:☐ No:☐ If yes, please explain:_____

Gastrointestinal problems, heartburn, vomiting, diarrhea?

Yes:☐ No:☐ If yes, please explain:_____

Urinary problems, pain/discomfort, blood in urine?

Yes:☐ No:☐ If yes, please explain:_____

Skin problems, rashes, excessive dryness?

Yes:☐ No:☐ If yes, please explain:_____

Musculoskeletal problems, aches & pains, swollen joints?

Yes:☐ No:☐ If yes, please explain:_____

Neurological problems, numbness, headaches, paralysis?

Yes:☐ No:☐ If yes, please explain:_____

Psychiatric problems, depression, anxiety?

Yes:☐ No:☐ If yes, please explain:_____

Family & Social History

Do any medical or eye diseases run in your family?

Yes:☐ No:☐ If yes, please explain:_____

Do you smoke?

Yes:☐ No:☐ If yes, how much?_____

Do you drink alcohol?

Yes:☐ No:☐ If yes, how much?_____

Are you currently employed or a full time/part time student?

Yes ☐ No:☐ If yes, how many hours per week/credits?_____

How did you hear about Old Town Optical?

Friend/Relative:☐ Our Website:☐ Newspaper:☐ Referral:☐ Phonebook:☐

Other:☐ _____

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts ninety days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be directly to Old Town Optical. I understand that if Old Town Optical does not participate with my primary and/or secondary insurance, it is my responsibility to submit the claim. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature:_____Date:_____

Would you like a copy of Dr. Baas' Notice of Privacy Practices?

Yes:☐ No:☐

Signature:_____Date:_____

Doctors Signature:_____Date:_____