PATIENT REGISTRATION AND MEDICAL HISTORY

Name:_____ Date:_____
Address:_____ Email:_____
Street City State Zip
Preferred Phone: _____ Occupation: _____
Date of Birth: _____ Gender ___ Marital Status: M D S W SS#_____

Who is Responsible for this account? _____Relation to patient_____
Insurance: Vision _____Medical _____
Insured Name: _____ Insured Date of Birth _____
Please present insurance cards to the receptionist.

Last Eye Exam Date and by whom: _____
How did you hear about us?_____
Chief Eye Problem today:_____

PLEASE LIST ALL MEDICATIONS YOU TAKE REGULARLY (or supply a list to the receptionist) Drug Allergies

1_____4_____ 1._____
2_____5_____ 2._____
3_____6_____ 3._____

If indicated today, what kind of vision correction would you prefer? ____Glasses ____Contact Lenses

Release of Patient Information

Please list family members or other persons, if any, whom we may inform about your general medical health, our who you would like to pick up materials for you:

1_____ 2_____
3_____

Can confidential messages be left on your answering machine or cell phone? _____Yes _____No

Patient or Guardian Signature_____ Date _____

HIPAA Notice of Privacy Practices

I have been presented a copy of the HIPAA privacy act. I understand the content. I know that at any time I can request my own personal copy of the form.

Patient or Guardian
Signature_____Date_____

Name_____ **Date**_____

Do you wear glasses? _____ Do you wear contact lenses? _____If so, Type and brand _____

Height____Weight____Smoker___Yes___No____ In the past Alcohol user____yes____no____per day____

Medical Doctor_____ Are you pregnant or nursing? ____yes ____no

Please list any surgeries, including eye surgeries:

_____

_____

REVIEW OF SYSTEMS: Please indicate if you (*the patient*) or a family member (*parent, grandparent, brother, sister*) ever had any of the following:

	Patient	Family Members
Amblyopia, crossed or lazy eye	**YES NO**	
Cataracts	**YES NO**	
Infection, injury, or Iritis	**YES NO**	
Glaucoma	**YES NO**	
Macular Degeneration	**YES NO**	
Other Retinal disease, including bleeding or detachment	**YES NO**	
Cardiovascular problems (HBP, high cholesterol, heart disease, heart attack, Congestive heart failure)	**YES NO**	
Endocrine problems (diabetes, high/low thyroid)	**YES NO**	
Neurological problems (stroke, numbness, weakness, headaches, paralysis, seizures)	**YES NO**	
Ear, nose, throat (hearing loss, sinus problems, throat issues)	**YES NO**	
Gastrointestinal/liver (reflux, stomach ulcer, hepatitis, cirrhosis, gallbladder)	**YES NO**	
Genital/urinary (renal failure, urinary tract infection, STDs, blood in urine)	**YES NO**	
Blood or lymph problems (anemia, leukemia, HIV/AIDS, lymphoma)	**YES NO**	
Skin disease (rash, eczema, psoriasis, rosacea, sores)	**YES NO**	
Musculoskeletal problems (osteoarthritis, joint pain, muscle aches, swollen joints)	**YES NO**	
Psychiatric problems (anxiety, bipolar, depression, schizophrenia, autism)	**YES NO**	
Respiratory problems (asthma, COPD, emphysema, bronchitis, wheezing)	**YES NO**	
Autoimmune disease (Lupus, Crohn's, Rheumatoid arthritis, Psoriatic arthritis)	**YES NO**	
Cancer? If so which type?		
Other conditions not mentioned?		

Do you currently have any of the following? (Circle all that apply)

Loss or Change in vision	**YES**	**NO**
Blurry vision	**YES**	**NO**
Pain or Irritation	**YES**	**NO**
Watery or Itchy eyes	**YES**	**NO**
Flashes of light	**YES**	**NO**
New Floaters	**YES**	**NO**
Dry eyes	**YES**	**NO**
Cornea Disease	**YES**	**NO**
Light Sensitivity	**YES**	**NO**
Active Allergies	**YES**	**NO**

The information I have provided is accurate and complete to the best of my knowledge. I don not hold my Optometrist or Baldwin Optical responsible for any errors or omissions that I may have made in the completion of these forms.

I authorize the release of my medical information necessary to process a claim on any insurance listed. I hereby assign to and authorize payment directly to Baldwin Optical for all benefits payable under such an insurance policy. I realize that the insurance benefits may not pay all the bill, and I agree to pay the difference of the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all costs of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection.

Signature (Patient or Guardian)_____ **Date**_____

Baldwin Optical

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DIGITAL RETINAL IMAGING

Bethany Lyn, O.D.

Dr. Bethany Lyn is pleased to inform you of the addition of an instrument that compliments her comprehensive eyecare. DIGITAL RETINAL IMAGING is a technology that allows viewing of the retina by the doctor and patient. The image aids by establishing a baseline of the inside of your eyes, as the old saying goes: “a picture is worth a thousand words”.

Dr. Lyn can then compare the image with future images and carefully observe any changes. She believes this will promote early diagnosis of many abnormal ocular conditions, some of which can result in permanent vision loss if not caught and treated in a timely manner.

This is an optional addition to your examination today and is **not covered by insurance**. Dr. Lyn recommends this image for all her patients. **The fee is only $28.00.**

_____ Please perform baseline DIGITAL RETINAL IMAGING as an optional additional procedure to my examination.

_____ I do not wish to have baseline DIGITAL RETINAL IMAGING performed.

_____ _____

Patient/Guardian Signature Date