

EYE CITY, LLC.
George R. Walters, M.D.
Patient Registration Form

Date _____

Patient Information:

Name _____ D.O.B. _____ Age _____

SSN# _____ Sex (Circle one) M F Marital Status _____

Address _____ City, State, Zip _____

Place of Business _____ Occupation _____

Business Address _____ City, State, Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone(____) _____

In Case of Emergency:

Name: _____ Relationship to patient: _____

Phone number:(____) _____ Alternative number: (____) _____

Responsible Party:

Name _____ Relation to Patient: Spouse Parent Guardian

D.O.B. _____ SSN# _____

Address _____ City, State, Zip _____

Place of Business _____ Occupation _____

Business Address _____ City, State, Zip _____

Primary Insurance:

Name _____ Policy # _____ Group # _____

Address _____ City, State, Zip _____

Policy Holder Name _____ D.O.B. _____ SSN# _____

Employer _____ Work Phone (____) _____

Employer's Address _____ City, State, Zip _____

Secondary Insurance:

Name _____ Policy # _____ Group # _____

Address _____ City, State, Zip _____

Policy Holder Name _____ D.O.B. _____ SSN# _____

Authorized signature is on file. By signing, I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered. I understand and agree that: 1) I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read) and understand the Notice; 2) I am fully responsible for all the charges to me including the balance remaining after payment of insurance benefits (as per your insurance contract); 3) A \$31.87 fee will be charged on each returned check; 4) Payment is expected on the day services are rendered unless prior arrangements are made; and 5) That the information in this paragraph may not be altered or amended by me.

****All co pays are due at the time of service.**

Patient or Responsible Party Signature: _____ **Date:** _____

EYE CITY MEDICAL RECORD				REPORT OF MEDICAL HISTORY				DATE:						
NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons														
1. NAME OF PATIENT (Last, First, Middle)						2. DATE OF BIRTH			a. AGE					
3. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)														
b. LIST ALL MEDICATIONS (including contraceptives, aspirin, over the counter medications):						List any medications you are allergic to: (indicate "None" if not allergic to meds)								
c. ALLERGIES (If yes, list below. Include insect bites/stings and common foods)						d. HEIGHT		e. WEIGHT						
4. PAST/CURRENT/FAMILY MEDICAL HISTORY														
EYE HISTORY		Y	N	N/A	MEDICAL HISTORY		Y	N	N/A	FAMILY HISTORY		Y	N	Relationship
Do you wear glasses?					Emphysema?					Blindness?				
Do you wear contacts?					Diabetes?					Cataract?				
Do you have Cataracts?					Heart Disease/Surgery?					Crossed Eyes?				
Do you have Glaucoma?					High Blood Pressure?					Glaucoma?				
Do you have Macular Degeneration?					Vascular Disease?					Macular Degeneration?				
Do you have Distorted or Blurred Vision?					Thyroid trouble or Goiter?					Retinal Detachment/ Disease?				
Loss of Side Vision?					Muscle or Joint Pain?					Arthritis?				
Excessive Tearing/Watering?					Blood Transfusion?					Stroke?				
Serious Eye Injury?					Anemia?					Cancer?				
Flashes/ Floaters in Vision?					Bleeding Problems?					Diabetes?				
Eye Pain or Soreness?					Taking Blood Thinner?					Heart Disease?				
Double Vision?					Are you pregnant or nursing?					High Blood Pressure?				
Dry Eye?					Tested Positive for T.B.?					Kidney Disease?				
Chronic Infections of Eye or Lid?					Do you experience Headaches/Migraines?					Thyroid Gland Issues?				
Mucous Discharge?					Do you experience Seizures?					Others:				
Redness or Itching?					Recent Weight Loss/Gain?									
Sandy or Gritty Feeling?					Auto-Immune Disease?									
Burning?					Do you drink alcohol?									
Sties or Chalazion?					Do you use illegal drugs?									
Crossed eyes?					Have you been exposed to Hepatitis?									
Lazy eye?					Have you been exposed to HIV?									
Eye surgery?					Immunizations up to date?									
MEDICAL HISTORY					Asthma?									
Liver Disease?					Chronic Cough?									
Chronic Bronchitis?					Allergies/Hay Fever?									
Do you use tobacco products?					Arthritis, Rheumatism or Bursitis?									

Would you like to know more about? (Check all that apply)

- Lasik
- Cataracts/ Crystal Lens
- Clear Lens

Patient Signature: _____