7775 S. Rainbow Blvd., Ste. 110
Las Vegas, NV 89139

ELITE EYE CARE

Phone 702.648.1515
Fax 702.617.1850

PATIENT REGISTRATION FORM

LAST NAME	FIRST NAME	MI	DATE	
STREET ADDRESS			SOCIAL SECURITY #	
CITY	STATE	ZIP	DATE OF BIRTH	
HOME PHONE	CELL PHONE		AGE	☐ MALE ☐ FEMALE
EMAIL ADDRESS			MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED	
EMPLOYER'S NAME				
OCCUPATION				
SPOUSE OR PARENT'S NAME				

HOW DID YOU HEAR ABOUT ELITE EYE CARE?

☐ FRIEND _____ ☐ PATIENT _____ ☐ INSURANCE LIST ☐ INTERNET

☐ MAGAZINE _____ ☐ ANOTHER DOCTOR _____ ☐ YELLOW PAGES ☐ SIGN

NOTICE OF PRIVACY PRACTICES

I have reviewed the **HIPPA** notice of privacy practices. I understand I may request a copy of this form

PATIENT'S SIGNATURE (required)_____ **DATE** _____
Parent if patient is a minor

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VISION INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	ID #	RELATIONSHIP TO MEMBER
MEMBER'S NAME	MEMBER'S EMPLOYER	MEMBER'S DATE OF BIRTH
SECONDARY INSURANCE COMPANY	ID #	RELATIONSHIP TO MEMBER
MEMBER'S NAME	MEMBER'S EMPLOYER	MEMBER'S DATE OF BIRTH

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	ID #	RELATIONSHIP TO MEMBER
MEMBER'S NAME	MEMBER'S EMPLOYER	MEMBER'S DATE OF BIRTH
SECONDARY INSURANCE COMPANY	ID #	RELATIONSHIP TO MEMBER
MEMBER'S NAME	MEMBER'S EMPLOYER	MEMBER'S DATE OF BIRTH

DILATION

Dilating the pupil with eye drops allows the Doctor a much better view inside the eye - to detect problems such as glaucoma, cataracts, retinal detachments, macular degeneration, diabetes, and high blood pressure often before any obvious symptoms. Without the dilation, the doctor has a limited view of the interior of the eye and would not be able to detect any tears, holes, or hemorrhages that occur in the far periphery of the eye.
It is strongly recommended that all patients receive this evaluation. It is especially important for those patients who have a history of diabetes, high blood pressure, headaches, flashes of light or floaters, high nearsightedness, cataracts, or family history of glaucoma or retinal problems.

☐ I WOULD LIKE DILATION ☐ I DO NOT WISH TO HAVE DILATION

☐ I WOULD LIKE TO RESCHEDULE THE DILATION FOR ANOTHER DAY

PATIENT'S SIGNATURE (required)_____ **DATE** _____
Parent if patient is a minor

AGREEMENT

I certify that the given information is correct to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and practitioners. I authorize and request my insurance company to pay directly to the eye doctor. I understand that my vision or medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependants. In the event it becomes necessary to collect fees through litigation, the patient agrees to pay all collection fees, court costs, deposition fees, and reasonable attorney's fees incurred.

PATIENT'S SIGNATURE (required)_____ **DATE** _____
Parent if patient is a minor

I agree to the above

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MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME	DATE	NAME OF MEDICAL DOCTOR

MEDICAL HISTORY

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

List any medications you take (including; prescriptions, oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

List any major injuries, surgeries and/or hospitalizations you have had: _____

_____

_____

Check any of the following that you have had: ☐ crossed eyes ☐ lazy eye ☐ drooping eyelid ☐ prominent eyes ☐ glaucoma

☐ retinal disease ☐ cataracts ☐ eye infections ☐ eye injury description/explanation: _____

_____

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is you present pair of lenses? _____

Do you wear contact lenses? ☐ no ☐ yes If yes, how old is you present pair of lenses? _____

Type of contact lenses? ☐ rigid ☐ soft ☐ extended wear ☐ other: _____ Are they comfortable? ☐ no ☐ yes

Are you interested in contact lenses? ☐ no ☐ yes

Are you interested in laser vision correction? ☐ no ☐ yes

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this information directly with your doctor if you prefer.

☐ Yes, I would prefer to discuss my social history directly with my doctor. (check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes If yes, please describe:

_____

Do you use tobacco products? ☐ no ☐ yes If yes; type, amount and how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes; type, amount and how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes; type, amount and how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

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MEDICAL HISTORY QUESTIONNAIRE

Do you currently, or have you ever had any problems in the following areas:

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eye	☐	☐	☐
ENDOCRINE	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARIDOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia/Bleeding Problems	☐	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list any medications:

_____

_____

Please note any family history for the following conditions and describe your relationship (parent, grandparent, children, sibling; living or deceased):

DISEASE/CONDITION	NO	YES	?	**RELATIONSHIP TO YOU**
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other	☐	☐	☐	_____

Doctor's Signature _____ Date _____