HOUSTON EYE DOCTOR

NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form so that we will have accurate information on file for you. All information is strictly CONFIDENTIAL.

Patient Contact Information

First Name	______________	Street Address	______________
Last Name	______________	Suite/Apt.	______________
Daytime Phone	______________	City	______________
Mobile Phone	______________	State	______________
Email	______________	Zip Code	______________
Gender	______________	Date of Birth	______________
Social Security No.	______________		

Guardian Information *(if patient is under 18 years of age)*

First Name	______________	Street Address	______________
Last Name	______________	Suite/Apt.	______________
Daytime Phone	______________	City	______________
Mobile Phone	______________	State	______________
Email	______________	Zip Code	______________

Primary Insurance Information		Secondary Insurance Information	
Provider Name	______________	Provider Name	______________
Provider Phone	______________	Provider Phone	______________
Policy/I.D. No.	______________	Policy/I.D. No.	______________
Group No.	______________	Group No.	______________

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

- ◯ Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
- ◯ No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- ◯ The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms ______________________________ Date ______________

PATIENT HISTORY

Vision Correction History *(please check any that apply)*

- Amblyopia (lazy eye) ☐
- Blurred vision at a distance ☐
- Blurred vision at near ☐
- Burning ☐
- Double vision ☐
- Drooping eyelid(s) ☐
- Dryness ☐
- Eye pain and/or soreness ☐
- Floaters or spots ☐
- Fluctuating vision ☐
- Foreign body sensation ☐
- Halos ☐
- I experience regular headaches ☐
- I stopped wearing contact lenses ☐
- I stopped wearing glasses ☐
- Infection of eye or lid ☐
- Itching ☐
- Loss of peripheral vision ☐
- Loss of vision ☐
- Mucous discharge ☐
- Redness ☐
- Sandy or gritty feeling ☐
- Sensitivity to light/glare ☐
- Strabismus (crossed eye) ☐
- Tired eyes ☐
- Watery eyes ☐

Glasses History *(check all that apply)*

What glasses do you own?

- Backup pair ☐
- Bifocals ☐
- Distance ☐
- Progressive lens ☐
- Reading ☐
- Safety glasses ☐
- Single vision ☐
- Sports glasses ☐
- Sunglasses ☐
- Trifocals ☐

Other:

How many hours per day do you spend using a computer? __________

Check any that apply

- Allergic to nickel (frames) ☐
- I do not want to wear glasses ☐
- Incorrect prescription ☐
- Need spare glasses ☐
- Need sunglasses with UV ☐
- Problems with current glasses ☐
- Problems with glare ☐
- Problems with night vision ☐

Contact Lens History *(check all that apply)*

What brand of contacts do you wear? ______________________________

How old are your current contacts? ______________________________

How often do you replace them? ______________________________

What solution do you use for soaking? ______________________________

What is your typical wearing schedule? ______________________________

Check any that apply

- I do not want to wear contacts ☐
- Incorrect prescription ☐
- Interested in non-surgical correction ☐
- Interested in refractive laser surgery ☐
- Need spare contacts ☐
- Problems with current contacts ☐
- Would like to change my eye color ☐

Family History *(check all that apply)*

- Blindness ☐
- Diabetes ☐
- Eye turn/lazy eye ☐
- Glaucoma ☐
- Hypertension ☐
- Macular degeneration ☐

Allergies *(please list)*

- None ☐

PATIENT HISTORY

General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? ____________________

Primary care physician name ____________________

Primary care physician phone ____________________

Please list all eye conditions you have experienced:

Surgeries:

Do you have any of the following?

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart disease ☐
- High cholesterol ☐
- HIV ☐
- Hypertension (high blood pressure) ☐
- Migraines/headaches ☐
- Multiple sclerosis (MS) ☐

Other:

Referral Information

Why did you visit us?

- Referred by your doctor ☐
- Visited our website ☐
- Found us on social media ☐
- Referred directly ☐

Keep in touch

Facebook email ____________________

@Twitter handle ____________________

Questions and notes

Do you have a question? Concern? We want to know.