Medical & Surgical Eye Specialists, Inc.

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Chesapeake, Virginia 23320
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PATIENT REGISTRATION

Patient Name				**Salutation**	
Birthdate		**Age**		**Birth State**	
Sex				**SS #**	
Address					
Address Type				**Country**	

COMMUNICATION					
Preference	☐Email ☐Cell ☐Home phone ☐Work phone ☐Other				
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Carrier**			
Email					

INFORMATION			
Plan Type			
Primary Language		**Special Needs**	
Race		**Ethnicity**	
Marital Status		**Mother's Maiden Name**	
Occupation		**Employer**	

ACCOUNT RESPONSIBLE **(If the patient is a minor, please complete this section)**					
Responsible				**Salutation**	
Relationship		**Birthdate**		**SS #**	
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

PRIMARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

INSURANCE INFORMATION (if already listed above you may skip or use to correct insurance information)			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

EMERGENCY CONTACT:

Name:

Telephone Number:

Relationship: **Sex:**

Is this person allowed access to you medical information? ☐ **Yes** ☐ **No**

AUTHORIZATION FOR MEDICAL CARE AND NOTICE OF PRIVACY PRACTICES

I hereby authorize treatment to the patient by the physician and/or staff of Medical & Surgical Eye Specialists. This authorization specifically includes the use of dilating eye drops which will result in temporary blurred vision. I also authorize release of any medical information necessary to process the insurance, and I authorize direct payment to Medical & Surgical Eye Specialist, Inc. I accept responsibility for payment of all charges incurred, as well as attorney and collection fees of 33.33% should such action become necessary. By my signature, I also acknowledge that I have received a copy of and read the Medical & Surgical Eye Specialists ' Summary Notice of Privacy Practices.

Today I will be using (pick one): ☐ medical insurance ☐ vision insurance (e.g., VSP, EyeMed, Superior)

Signature:_____Date: _____

Who is your Medical Doctor (PCP):

Reason for your visit today:

Please list your Current Medications:

Review of Systems:	
General Symptoms (Fever, Weight Loss, Fatigue...)	
Eyes/Vision: (Blurred, Redness, Pain, Double Vision, Discharge, Glare, Haloes, Itchy, Watery)	
Cardiovascular: (Chest Pain, Palpitations)	
Ears, Nose, Mouth, Throat (Hearing Loss, Nasal Congestion)	
Respiratory: (Shortness of Breath, Cough)	
Gastrointestinal: (Heart Burn, Indigestion)	
Genitourinary: (Frequent Urination, Discolored Urine)	
Musculoskeletal: (Sore Muscles, Joint Pain)	
Integumentary: (Skin rash, Itchy Skin)	
Neurological: (Weakness, Poor Memory)	
Psychiatric: (Depression, Mood Swings)	
Endocrine: (Hot Flashes, Excessive Thirst)	
Hematologic/Lymphatic: (Easy Bruising, Swollen Lymph Nodes)	
Allergic/Immunologic: (Hay Fever, Frequent Colds)	
Other Diseases or Issues not listed:	

Past, Family and Social History: (Please check all that apply)					
Condition	You	Family	Condition	You	Family
Cataracts	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Diabetes	☐	☐
Crossed Eyes	☐	☐	High Cholesterol	☐	☐
Lazy Eye	☐	☐	Heart Attack	☐	☐
Macular Degeneration	☐	☐	Stroke	☐	☐
Other Eye Disease	☐	☐	Congestive Heart Failure	☐	☐
Rheumatoid Arthritis	☐	☐	Asthma	☐	☐
Lupus	☐	☐	Emphysema	☐	☐
Sarcoidosis	☐	☐	Tobacco Use	☐	☐
Thyroid Disorder	☐	☐	Drink Alcohol	☐	☐
Cancer or Tumors	☐	☐	HIV/AIDS	☐	☐

Please list any surgeries you have had and dates: