ALPINE FAMILY EYECARE
REGISTRATION FORM

(Please Print)

Today's date:	**Primary care physician:**

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred name:	Spouse's name:	Parent/Guardian:

Street address: (Include apartment number)	Social security number:	Birth date:	Age:	Sex: ☐ M ☐ F

City:	State:	Zip Code:	Email Address:

Occupation:	Employer:

Home number: ( )	Cell number: ( )	Work number: ( )

How did you hear about us? (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Drive by sign

☐ Referral card	☐ Internet	☐ Live nearby	☐ Friend or relative referral	☐ Other:

Other family members seen here:

MEDICAL INFORMATION

Have you been diagnosed with or treated for any of the following?

Diabetes ☐ Type:	Date of diagnosis:

Have you been diagnosed with or treated for any of the following?	☐ Thyroid	☐ Nerve disorder	☐ Gastrointestinal	☐ Heart disease

☐ Chronic respiratory	☐ Stroke	☐ Hypertension	☐ High cholesterol	☐ Depression	☐ Cancer	☐ Migraine	☐ Hepatitis

☐ HIV or Compromised Immune System	☐ Other

Do you use?	☐ Tobacco/Cigarettes	☐ Alcohol	☐ Other substances

Current Medications

Medicinal & Environmental Allergies

Are you pregnant? ☐ Yes ☐ No	If so, how many months?

Do you experience any of the following?	☐ Blurred vision	☐ Double vision	☐ Recent flashes	☐ Recent floaters
☐ Ultra light sensitive	☐ Excessive burning	☐ Excessive tearing	☐ Excessive itching	☐ Unexplained headaches

Have you ever had an eye injury? ☐ No ☐ Yes:	Eye Surgery? ☐ No ☐ Yes:

Do you currently wear glasses? ☐ Yes ☐ No	Do you currently wear contacts? ☐ Yes ☐ No Brand:

FAMILY HISTORY

Has an immediate family member been diagnosed or treated for any of the following?

☐ Diabetes Relation:	☐ Glaucoma Relation:	☐ Cataracts Relation:

☐ Hypertension Relation:	☐ Macular degeneration Relation:

☐ Retinal detachment Relation:	☐ Other eye conditions: Relation:

Any questions or vision concerns?

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED