PATIENT REGISTRATION

Referred by: _____ **Family Doctor:** _____

Patient Name: _____ Today's Date: _____/_____/_____/
Last First Middle

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ M ☐ F

Social Security #: _____ Date of Birth: _____/_____/_____/ Age: _____

Employer/Parent's Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____

Spouse Name (Parent name if minor): _____ Spouse/Parent Work Phone: _____

Person to notify in case of emergency (other than spouse): _____

Phone Number: _____ Relationship: _____

Primary Insurance Company		
ID#	Group#	Effective Date
Subscriber Name	Relationship to Patient	
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group#	Effective Date
Subscriber Name	Relationship to Patient	
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to **Balouris Eye Center, PC** to be applied to my account for services rendered. **I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment.** I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance, and uncovered charges that apply.

Signature of Patient (or parent if a minor): _____ **Date:** _____/_____/_____/

PATIENT REGISTRATION—CONTINUED

Dilating drops may be necessary to examine your eyes. This could cause blurred vision which could make walking and driving more difficult, therefore proper precautions should be taken.

_____

Signature of Patient (or parent if a minor)

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____

Mail Order Pharmacy: _____ Phone: _____

HEALTH HISTORY

Please check any of the following conditions that apply to you.

General Medical Problems	Yes	No
Allergies		
Arthritis		
Asthma		
Cancer		
Diabetes		
Emphysema		
Headaches / Migraines		
Heart Problems		
Hepatitis / Aids		
Thyroid		
Other		

Past Eye Problems & Eye Surgeries	Yes	No
Cataract		
Diabetic Eye Disease		
Double Vision (Prisms Needed)		
Eye Trauma		
Glasses / Contacts		
Glaucoma		
Lazy Eye		
Macular Degeneration		
Refractive Surgery (such as LASIK or PRK to eliminate glasses)		
Retinal Detachment		
Other		

Family History	Yes	No
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Other		

If you have answered YES to any of the past eye problems or surgeries, or family history, please explain:

_____

_____

_____

_____

Allergies to Medications – Please List:

_____

_____

_____