# Patient Registration

Last Name:_________________________________ Sex: Male / Female

First Name:_________________________________ Date of Birth:_____________

Middle Initial:____________ Age:________

SSN: __________________

Address:_____________________________ Marital Status: Single, Married, Divorced, Widowed, or Other.

City:______________State:_______Zip:_________

Hm Ph:__________________ / Cell Ph:________________ / Wrk Ph:________________

Email Address:________________________________Fax # __________________

Employment Status: Full/Part Time; Student; Active duty Military; Retired

Employer:____________________________ / Occupation:__________________

How did you hear about us and who referred you? ___________________________

Who is your Primary Care Doctor? __________________________________

Insurance Info:

Insurance Type: 1._______________ 2.________________ 3.________________

Policy #:___________________________________

Subscriber Name: (Last):______________________ (First):________________________

Subscriber Date of Birth:________________ / SS#_____________

Other:_____________________________________

(A) FINANCIAL RESPONSIBILTY AGREEMENT:

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Dr. Michael Mc Mann,MD,LLC / McMann Eye Institute. A copy of this can be used as an original for insurance purpose. I agree to pay my co-payment portions as services are provided. If there is any balance owing, I agree to pay promptly upon receipt of the monthly statement. I am aware of the additional charge for returned checks of $25.

(B) ACKNOWLEDGEMENT OF PRIVACY NOTICE:

I have been provided an opportunity to read and review the NOTICE OF PRIVACY PRACTICES; or to receive a copy per my request ($0.50) as required by HIPPA regulation.

___________________________________________ ______________

Patient's Signature / Legal Guardian Date

Patient Name:______________________________ Date:________________

Date of Birth:_________________________ Date of last eye exam:________________

List any medications you currently take (prescription and over-the-counter):_______________________
_______________________________________________________________________________________

Do you have new allergies to any medications, since your last visit? YES NO
If YES, list the medications:_________________________________________________________________

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):_______________________________________________________________________

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.):_____________________
_______________________________________________________________________________________

DO YOU **CURRENTLY** HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?:

| If **YES**, please provide information. | **YES** | **NO** | **Details** | **Since when?** |
|---|---|---|---|---|
| **EYES** | | | | |
| Loss of vision | | | | |
| Blurred vision | | | | |
| Fluctuating vision | | | | |
| Distorted vision (halos) | | | | |
| Glare or light sensitivity | | | | |
| Loss of side vision | | | | |
| Double vision | | | | |
| Dryness | | | | |
| Mucous discharge | | | | |
| Redness | | | | |
| Sandy or gritty feeling | | | | |
| Itching | | | | |
| Burning | | | | |
| Foreign body sensation | | | | |
| Excess tearing or watering | | | | |
| Eye pain or soreness | | | | |
| Infection of eye or lid | | | | |
| Tired eyes | | | | |
| Crossed eyes, lazy eye | | | | |
| Drooping eyelid | | | | |
| **ALLERGIC/IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, etc.) | | | | |
| **CARDIOVASCULAR** (high BP, racing pulse, etc.) | | | | |
| **GENERAL/CONSTITUTIONAL** (fever, weight loss, other) | | | | |
| **ENDOCRINE** (diabetes, hypothyroid, etc.) | | | | |
| **GASTROINTESTINAL** (stomach upset, diarrhea, constipation, etc.) | | | | |
| **GENITAL, KEDNEY, BLADDER** (painful urination, frequent urination, impotence, etc.) | | | | |
| **BLOOD/LYMPH** (cholesterolemia, anemia, etc.) | | | | |
| | | | | |

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|---|---|---|---|---|
| DO YOU **CURRENTLY** HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?: | **YES** | **NO** | **Details** | |
| **IMMUNOLOGIC** (mumps, chickenpox, measles, etc.) | | | | |
| **SKIN** (pimples, warts, growths, rash, etc.) | | | | |
| **MUSCLES, BONES, JOINTS** (joint pain, stiffness, swelling, cramps, etc.) | | | | |
| **NEUROLOGICAL** (numbness, headache, etc.) | | | | |
| **PSYCHIATRIC** (anxiety, depression, insomnia, etc.) | | | | |
| **RESPIRATORY** (asthma, COPD, bronchitis) | | | | |

| **FAMILY HISTORY** | **M**= mother **F**=father **S**=siblings **GP**=grandparent | | |
|---|---|---|---|
| DISEASE | **YES** | **NO** | **RELATIONSHIP TO PATIENT** |
| Blindness | | | |
| Glaucoma | | | |
| Arthritis | | | |
| Cancer | | | |
| Diabetes | | | |
| Heart disease or high blood pressure | | | |
| Kidney disease | | | |
| Lupus | | | |
| Stroke | | | |
| Thyroid disease | | | |
| Other | | | |

**SOCIAL HISTORY**

Do you drive? **YES** **NO**

Do have difficulty when driving: **YES** **NO**

Do you have problems with night vision? **YES** **NO**

Have you ever tried to wear contact lenses? **YES** **NO**

Do you currently wear glasses? **YES** **NO**

(if yes, how long have you had your current prescription?): ________________________________________

Do you drink alcohol? **YES** **NO**

If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? **YES** **NO**

If YES: ½ pack/day 1pack/day 1+pack/day