

Virginia Pediatric Eye Center
Registration

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____
SSN _____ Sex: M F Date of Birth _____
Address _____
City _____ State _____ Zip _____
Primary Phone Number _____ Secondary Phone Number _____
Pediatrician _____ Phone Number: _____
Patient lives with: Mother Father Both Other(Name and Relationship) _____
Referring Physician: _____
Pharmacy Name: _____ Phone Number: _____
Additional Contact (other than parent): Name: _____
Relationship _____ Phone Number: _____

MOTHER/GUARDIAN

Name _____
Address:(Check if Same as Patient _____)
Address _____
City _____ State _____ Zip _____
DOB _____ Cell-Ph _____
SSN _____
Email Address _____
Employer Name _____

FATHER/GUARDIAN

Name _____
Address:(Check if Same as Patient _____)
Address _____
City _____ State _____ Zip _____
DOB _____ Cell-Ph _____
SSN _____
Email Address _____
Employer Name _____

PRIMARY INSURANCE

Insurance Name _____
Subscriber _____
Relationship to Patient _____
Subscriber ID _____
Subscriber SSN _____
DOB _____

SECONDARY INSURANCE

Insurance Name _____
Subscriber _____
Relationship to Patient _____
Subscriber ID _____
Subscriber SSN _____
DOB _____

AUTHORIZATION FOR MEDICAL CARE AND NOTICE OF PRIVACY PRACTICES

I hereby authorize treatment to the patient by the physicians and/or staff of Virginia Pediatric Eye Center (VPEC). I also authorize release of medical information necessary to process the insurance. I understand that failure to cancel future appointments with less than 24 hours notice may incur a fee of up to \$50. I agree to reimburse VPEC the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fees, VPEC incurs in such collection efforts. I also that I have been given the opportunity to read the Notice of Privacy Practices for VPEC; this notice describes how medical information about me may be used and disclosed and how I can get access to this information. (A copy of the privacy notice is available upon request.)

Signature

Date

Office staff/system update completed by _____ Date _____

PATIENT'S MEDICAL HISTORY Last Eye Exam (Date) _____ (Doctor) _____

What is the problem that brings you to Virginia Pediatric Eye Center? _____

Has there been any treatment for this problem? If so, please describe: _____

Has the patient ever had any eye diseases (e.g. cataracts, glaucoma, wandering or "lazy" eye, retinal detachment)? If so, please describe: _____

Are there other physicians involved in the patient's eye care? If so, please list name, address, and phone number of the doctor(s): _____

Is there any family history of medical problems or eye disease (e.g. high blood pressure, cancer, cataracts, strabismus/lazy eye, diabetes/sickle cell trait, glaucoma, etc)? If yes, please explain: _____

Has the patient ever been diagnosed and/or treated for any medical condition (e.g. diabetes, juvenile rheumatoid arthritis, congenital defects, genetic disorders, ADHD, etc)? If so, please explain, _____

Has the patient ever had any surgery? If so, please provide date and procedure: _____


Has the patient ever been hospitalized? If so, please provide date and reason: _____

Please list the patient's present medications, including vitamins and over-the-counter drugs: _____

Please list the patient's allergies: _____

REVIEW OF SYSTEMS

Does the patient have any of the following problems:	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eyes: (If YES, please CHECK )

Loss of vision	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	Distorted vision (halos)	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Dryness	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	Sandy or gritty feeling	<input type="checkbox"/>	Itching	<input type="checkbox"/>
Burning	<input type="checkbox"/>	Foreign body sensation	<input type="checkbox"/>	Excess tearing/watering	<input type="checkbox"/>
Occasional tearing	<input type="checkbox"/>	Glare/Light sensitivity	<input type="checkbox"/>	Eye pain or soreness	<input type="checkbox"/>
Chronic infection of eye/lid	<input type="checkbox"/>	Styes, Chalazion	<input type="checkbox"/>	Fluctuating visual acuity	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>				