Virginia Pediatric Eye Center
Registration

PATIENT INFORMATION

Last Name _____ First Name_____ Middle _____

Sex: M F Date of Birth_____

Address_____

City_____ State_____ Zip_____

Cell Phone_____Home Phone_____ Parent's Work Phone:_____

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 Phone_____

Last 4 Digits of SSN_____

Email Address_____

Employer Name_____

FATHER/GUARDIAN

Name_____

Address:(Check if Same as Patient_____)

Address_____

City_____State _____Zip_____

DOB_____Cell Phone_____

Last 4 Digits of SSN_____

Email Address_____

Employer Name_____

PRIMARY INSURANCE

Insurance Name_____

Subscriber_____

Relationship to Patient_____

Subscriber ID_____

Subscriber SSN(if required by plan)_____

DOB_____

SECONDARY INSURANCE

Insurance Name_____

Subscriber_____

Relationship to Patient_____

Subscriber ID_____

Subscriber SSN(if required by plan)_____

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 acknowledge 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

Relationship to patient (Please circle one) – mother father grandparent stepparent legal guardian Other _____

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	☐	☐	_____
Ear/nose/throat problems (hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart problems (chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic problems (numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (depression, anxiety)	☐	☐	_____

Eyes: (If YES, please CHECK Y)

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