New Patient Registration Form

Patient Details

Legal Name: ____

☐ Male ☐ Female

Date of Birth: ____________________ Preferred Name: ____________________________________

Address: ____

City: ______________________________ State: ____________________ Zip: ____________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________

Social Security Number: ______________________ Email Address: ______________________________

Martial Status:	☐ Single	☐ Married
	☐ Divorced	☐ Widowed

Occupation: ____________________________________

Employer: ____________________________________

Pharmacy Name/Location: ____

Primary Care Physician: ____

Hobbies/Sports: ____

How did you hear about our practice: ____

Do you currently wear contacts or have you worn them in the past: ☐ Yes ☐ No ☐ Previously/Past

Please check if you use any of the following: ☐ Alcohol ☐ Drugs ☐ Smoking/Tobacco

Please list any medications you are taking, including OTC, vitaminds, and/or suppliments:

____

____

____

Please list any general allergies and/or allergies to medications:

____

____

Family History

Please indicate who in your immediate family (parents, siblings, grandparents, aunts, uncles) currently has or has had the following:

Glaucoma: ____

Cataracts: ____

Macular Degeneration: ____

Hypertension (high blood pressure:) ____

Cancer: ____

Heart disease: ____

High Cholesterol: ____

Diabetes: ____

Thyroid disorder: ____

Other (please specify): ____