

WELCOME TO CASCADE EYE M.D.s

*** PLEASE COMPLETE BOTH SIDES OF REGISTRATION FORM ***

Place patient sticker here

Today's Date: _____

Patient's Name: _____ Male Female
Last First Middle

Address _____ Date of birth: _____

City _____ State _____ Zip _____ SSN: _____

Home phone () _____ Work phone () _____ Cell phone () _____

Employer _____ Occupation _____ Marital Status _____

Emergency contact _____ Phone number () _____

DID A HEALTH CARE PROVIDER REFER YOU FOR THIS VISIT? Yes No

If yes, name of clinician and clinic: _____

PRIMARY CARE PHYSICIAN _____ Phone number () _____

OTHER DOCTORS THAT TREAT YOU: _____

WHAT IS YOUR PRIMARY REASON(S) FOR TODAY'S VISIT? _____

INSURANCE INFORMATION

*Please present primary and secondary insurance cards at time of check-in for your appointment.

*If you do not have insurance coverage, payment is due on the date of service.

*If you have a work-related injury, you must provide us with the L&I claim number.

***Routine vision is sometimes provided through a vision plan that is separate from your medical plan.**

Please check with your plan regarding your routine vision coverage.

LIST YOUR CURRENT MEDICATIONS

Check here if you do not currently take any medications

MEDICATION ALLERGIES

Check here if no medication allergies

INJURY INFORMATION

Is your visit related to an injury? Yes No Date of injury: _____ Right eye Left eye Both

Place of injury: Home Work Auto Accident School Other (please specify): _____

If related to auto accident: Auto insurance claim filed? Yes No If yes, claim number: _____

If related to work injury: Employer at the time of the injury: _____ Phone: () _____

Has your employer been notified? Yes No Has L&I claim been filed? Yes No Claim No. _____

→PLEASE COMPLETE OTHER SIDE OF FORM →

YOUR PERSONAL OCULAR HISTORY:

- Prescription glasses (how old is prescription? ____ years) Readers (power: _____) Contact lens wearer
 Cataract Glaucoma Glaucoma suspect Diabetic retinopathy
 Crossed eye (strabismus) Patching one eye as a child Amblyopia Corneal disorder
 Retinal tear or detachment Macular degeneration Eye injury Eyelid disorder
 Other: _____
 Prior ocular or eyelid surgery(ies): _____ (include which eye and year)

FAMILY OCULAR HISTORY (patient's biological mother, father, siblings and grandparents):

- Cataract(s) Glaucoma Glaucoma suspect
 Crossed eye (strabismus) Macular degeneration Retinal tear or detachment
 Corneal disease Other: _____

YOUR PERSONAL MEDICAL HISTORY (check all that apply)

- Diabetes (year diagnosed _____, blood sugars range _____, last HbA1C if known _____)
 High cholesterol High blood pressure Coronary artery disease Other heart problems: _____
 Stroke or TIA Asthma COPD/emphysema Arthritis
 Thyroid disease HIV/AIDS Hay fever/allergies Eczema/dry skin
 Sinus disease Cancer (please specify): _____
 Other medical history: _____
 Previous surgeries or hospitalizations (and year): _____

SOCIAL HISTORY:

Do you smoke cigarettes (or cigars)? Yes No If yes, how many years: _____ How many packs per day: _____
Do you drink alcohol? Yes No If yes, how many drinks a week: _____ Do you chew tobacco? Yes No

REVIEW OF SYSTEMS – Do you CURRENTLY OR RECENTLY experience(d) any of the following:

Please circle specific problems below. Table with columns: YES, NO, If yes, please explain. Rows include: General (i.e. fever, unexpected weight loss/gain, night sweats or fatigue), Ear/nose/throat (i.e. hearing loss, infections, sore throat, sinusitis), Cardiac (i.e. chest pain, irregular heartbeat, palpitations), Respiratory (i.e. shortness of breath, wheezing or cough), Hay fever or seasonal allergies, Gastrointestinal (i.e. heartburn, abdominal pain, diarrhea, vomiting), Urinary or genital (i.e. pain with urination, frequency, blood in urine), Skin (i.e. rashes, dryness, rosacea, acne, non-healing sores, moles), Musculoskeletal (i.e. back pain, muscle aches, joint pain or swelling), Neurological (i.e. numbness, weakness, slurred speech, headaches, seizures), Endocrine (i.e. frequent urination, excessive thirst, missed periods, heat or cold intolerance, unexplained lactation, hot flashes), Psychiatric (i.e. depression, sadness, mania, hallucinations, anxiety).

▶ Patient signature** _____ Date: _____

** If someone other than the patient completed this form, please write your name and relationship to the patient:
Name: _____ Relationship: _____ Date: _____

(M.D. reviewed all patient history and ROS: Dr. Reinhardt _____ Dr. Kenny _____ Date _____)