Falcon Optical/Dryden Optometry P.C.

Patient Registration & Medical History Form

Full Name _____ Birth Date:____/___/___
Mailing Address:_____
Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____Referred By:_____
Email Address:_____ Primary Doctor:_____
Primary Medical Insurance:_____ Secondary Insurance:_____
* We must have a copy of all insurance cards,effective date, and date of birth of primary insured at the time of service*
HIPPA: I authorize Falcon Optical/ Dryden Optometry to talk to:_____
Emergency Contact:_____ Emergency Contact Phone Number: ( ) _____-_____
Primary Language:_____ Ethnicity:_____ Hispanic / Non Hispanic

Family History: _____No Problems ___Diabetes ___High Blood Pressure ___Cancer ___ Heart Disease ___Glaucoma ___ Macular Degeneration Other:_____
Social History: Smoke? ___No ___Former ___Yes: How Much:_____Alcohol? ___No ___Yes: How Much_____
Occupation:_____ ___Retired____Disabled___Student___Married___Single___Widowed
Hobbies: _____

Vision History: Do you currently wear glasses? Y / N Date/Place of you last exam:_____
Do you use a computer? Y/ N Hours per day___Do you experience dry eye? Y /N Sensitive to sunlight or glare? Y / N

Personal Ocular History/Eye Problems: (circle all that apply) Macular Degeneration, Glaucoma, Cataracts, Dry Eye, Eye Allergies, Cataract Surgery, LASIK, Eye Injuries, OTHER_____
General Health Problems: (circle all that apply) Stroke, Neurological Problems, Heart Problems (CHF, CAD, Murmur), High Blood Pressure, Cholesterol, Depression, Anxiety, Bipolar, ADHD, Muscles/Skeletal Problems, Respiratory Problems, COPD, Asthma, Urinary Problems, Kidney Problems, Acid Reflux, Crohn's Disease, Thyroid Problems, Arthritis, Autoimmune Problems, OTHER:_____
Cancer? _____Diabetes? Type/Diagnosed: _____
PLEASE LIST ANY:
Allergies:_____
Medications:_____
_____
_____
Surgeries:_____
_____

Patient Authorizations and Consent: I/We have authorized Falcon Optical/ Dryden Optometry to release any medical information that may be necessary for the medical benefit of processing applications for financial benefit. This includes but is not limited to my insurance company, workers comp, or social security administration. I/We hereby authorize Falcon Optical/Dryden Optometry to administer diagnostic and medical procedures as may be necessary for proper health care. I/We understand that I am responsible for payment of all charges. It is my responsibility to pay any deductible, copay, and any other balance not paid by my insurance company. I/We authorize insurance benefits to be paid directly to the provider. I/We authorize the doctor on staff to communicate with my primary care doctor and any specialists regarding the findings of my eye examination. This authorization will remain in effect until revoked by the patient or the patients guardian._____**(initial)**
To be completed by the patient or the legal representative of the Patient: I acknowledge that I have received or have access to Falcon Optical/Dryden Optometry P.C.'s Notice of Privacy Practices. _____(initial)

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____Date: ____/____/____
Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____Date: ____/____/____
Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____Date: ____/____/____
Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____Date: ____/____/____

Signature:_____Date: _____/_____/_____
Signature:_____Date: _____/_____/_____
Signature:_____Date: _____/_____/_____
Signature:_____Date: _____/_____/_____