Beachside Optometry
REGISTRATION FORM

Today's Date:	Family or Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	O Dr. O Mr. O Mrs. O Ms.	Birth date:	Age:	Sex: ◯ M ◯ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.: Cell no.:	Email address:
Occupation:	Employer:	Work phone no.:

How were you referred to us? Insurance, Yelp, Website, Walk By, Friend or Family member?

Who may we thank for referring you?

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Insurance Subscriber:	Birth date:	Address (if different):	Home phone no.:

Name of Vision Insurance:		ID #:	SS #:
Primary Medical Insurance	Group #:	Policy #:	PPO or HMO? Name of HMO?

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I (or my dependant) authorize my insurance benefits be paid directly to the Beachside Optometry. I understand that I am financially responsible for any balance. I also authorize Beachside Optometry or insurance company to release any information required to process my claims. I authorize the use of my signature on all insurance submissions. No refunds are given on glasses or contacts that are already made by our laboratory; remake or exchange only. All orders not dispensed within 30 days of notification will forfeit deposit unless prior arrangements are made.

Patient/Guardian signature   Date

Allergic/Immunological | **Genital, Kidney, Bladder**

☐	AIDS/HIV	☐	Frequent urination
☐	Allergy shots	☐	Kidney Stones
☐	Itchy Skin		
☐	Lupus		
☐	Rheumatoid		
☐	Seasonal allergies		

Blood/Lymph | **Muscles, Bones, Joints**

☐	Anemia	☐	Arthritis
☐	Bleeding problems	☐	Head or neck injury
☐	Cholesterol	☐	Joint pains
☐	Node swelling		

Cardiovascular | **Neurological**

☐	Heart Surgery	☐	Headaches
☐	High BP	☐	Migraines
☐	Palpitations	☐	Numbness
☐	Vascular disease	☐	Seizures

Ear, Nose, Throat | **Psychiatric**

☐	Allergies	☐	Anxiety
☐	Cough	☐	Depression
☐	Dry mouth/ throat	☐	Insomnia
☐	Hearing problems	☐	Mood changes
☐	Sinus		
☐	Speech		

Endocrine | **Respiratory**

☐	Diabetes	☐	Asthma
☐	Thyroid	☐	Bronchitis
		☐	COPD
		☐	Emphysema
		☐	Shortness of Breath

Gastrointestinal | **Skin**

☐	Constipation	☐	Acne
☐	Diarrhea	☐	Growths
☐	Reflux	☐	Rashes
☐	Ulcer		

General

☐	Excessive thirst	☐ **NO TO ALL**
☐	Fatigue	
☐	Fever	
☐	Sleep troubles	
☐	Weight gain	

Patient Social History

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced/Widowed

Use of alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco ☐ Never ☐ Previous but quit ☐ Currently: _________packs/day

Use of drugs ☐ Never ☐ Yes Type: ______________________frequency________________

Extensive exposure to: ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne particles

Name:______________________________ Date:______________

When was your last eye exam? ______________________

How many hours per day are you on a computer? ______________

Do you wear glasses? ☐ Yes ☐ No

Do you have prescription sunglasses? ☐ Yes ☐ No

Do you have computer glasses? ☐ Yes ☐ No

Are you interested in Lasik? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

If not, would you like to wear contacts? ☐ Yes ☐ No

Contact lenses require a yearly contact lens evaluation to ensure optimal health and vision. This is not part of a routine eye exam and is not usually covered by vision insurance. Before proceeding, please ask a staff member for an estimate of your charges today.

I would like to proceed with a contact lens evaluation today: ____________ (please initial)

I decline the contact lens evaluation. I understand that by declining, I will not be able to order contact lenses until an evaluation has been done: ____________ (please initial)

Medical	Self	Family		Self	Family		Self	Family
AIDS or HIV	☐	☐	Epilepsy	☐	☐	Migraines	☐	☐
Allergies	☐	☐	Gout	☐	☐	Pregnant	☐	☐
Anemia	☐	☐	Hepatitis	☐	☐	Shingles	☐	☐
Arthritis	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	Hypercholesterolemia	☐	☐	Tuberculosis	☐	☐
COPD	☐	☐	Hypertension	☐	☐			
Diabetes	☐	☐	Kidney Disease	☐	☐			

Ocular	Self	Family		Self	Family		Self	Family
Amblyopia	☐	☐	Dry Eyes	☐	☐	Lazy Eye	☐	☐
Blepharoplasty	☐	☐	Eye Injury	☐	☐	Macular Degeneration	☐	☐
Blind Eye	☐	☐	Eye Surgery	☐	☐	Ptosis/ Eyelid droopy	☐	☐
Cataract	☐	☐	Eye Turn	☐	☐	Retinal Detachment	☐	☐
Conjunctivitis	☐		Glaucoma	☐	☐			

Ocular Symptoms

Abrasion	☐	Dry eyes	☐	Flashes of light	☐	Itchy Eyes	☐	Sandy	☐
Blurry Vision	☐	Double Vision	☐	Floaters	☐	Light Sensitivity	☐	Stinging	☐
Burning	☐	Eye Infection	☐	Grittiness	☐	Metal in Eye	☐	Tearing	☐
Crossed Eyes	☐	Feels Something in Eye	☐	Headlight glare	☐	Night blurriness	☐	Watery	☐

Medications: ______________________________

Drug Allergies: ______________________________

PLEASE TURN OVER TO BACK SIDE