Vision Source™
Signature Eye Care

STEP 1 PATIENT REGISTRATION

Date: ____________

Mr. Mrs. Miss. Ms. Dr. Last: ______________________ First: ____________________ MI: _____

Date of Birth: _____/_____/_______ Sex: ☐ Male ☐ Female Social Security #: ________________

Race: ______________ Ethnicity: ☐ Hispanic ☐ Not Hispanic Height: _______ Weight: _______

Street Address: __________________________ City/State: ____________________ Zip: ________

Home Phone: ________________ Cell Phone: _________________ Work Phone: ______________

Email Address: _________________________ Preferred method of contact: ☐ Call ☐ Text ☐ Email

Employer/Occupation: _____________/_____________ School/Grade: _____________/______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse: ________________

List name(s) & age(s) of dependent children: ____

What is the major reason for your visit? ____

Are you currently wearing eyeglasses? ☐ Yes ☐ No Contact lenses? ☐ Yes ☐ No

If wearing contact lenses, what would you change about them? _____________________________

Do you work on a computer? ☐ Yes ☐ No How many hours per day? _________________________

When & where was your last eye exam? _____________________ Performed by Dr. ______________

I authorize the release of any medical or other information necessary to process insurance claims.

I authorize payment of vision/medical benefits to the physician for services rendered.

X____

Signature of Patient (Or Legal Guardian if Minor)

STEP 2 MEDICAL HISTORY

MEDICATIONS

- ☐ None
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

MEDICATION ALLERGIES: (☐ None)

- ______________________________

PRIMARY CARE PHYSICIAN

Name: ____________________________________

(Last) (First)

Address: __________________________________

____

Phone: ___________________________________

Fax: _____________________________________

Past Personal History

Please describe all serious illnesses, injuries, and surgeries: ______________________________

____

____