Kornmehl Laser Eye Associates

REGISTRATION FORM Today's Date ____/____/_____

Contact Demographic Information

Patient Name _________________________Nickname:_____________ DOB ____/____/_____

Address ___________________________________ City ________________________ State _____ Zip _______

Cell Phone # ___________________ Home Phone # ___________________ Work Phone __________________

Email Address ____________________________ Preferred Contact □ Cell □ Home □ Email

Employment Status □ Employed □ Retired □ Student (Full Time/ Part Time)

Employer Address ____ Occupation _______________________

Emergency Contact ________________________ Phone Number __________________

Relationship to Patient __________________________________

Gender Identity (Please check all that apply): Identifies as□ Male □ Female

□ Transgender Male/ Female to Male (FTM)□ Transgender Female/ Male to Female (MTF)

□ Gender non-conforming (neither exclusively male nor female)

□ Additional gender category/ Other, please specify: _______________________________________

Assigned Sex at Birth: □ Male □ Female**Pronoun:** □ He/ Him □ Her/She □They/ Them

Referral Source □ Physician _________________ □ Friend ________________ □ Internet □ Other ____________

Motivation for Laser Vision Correction □ Occupation □ Failure of Contacts □ Dislike Glasses □ Dry Eyes □ Sports/Activities □ **Here for Comprehensive Examination Only**

Preferred Pharmacy _________________ **Phone Number** ______________________

Pharmacy Address ____

Primary Care Physician ________________________**Address** _________________________**Phone #** ___________

Personal Authorization (Please choose one):

□ I wish to allow (Name)___________________________ DOB____/____/____ to receive information on my behalf regarding medical record information.

□ I wish to allow (Name) ___________________________ DOB____/____/_____ to receive information on my behalf regarding any billing/ financial information.

□ I do not wish to allow any person(s) to receive any information regarding my care or financial/ billing information.

____ _____/_______/_______

Patient Signature Date

Kornmehl Laser Eye Associates

Insurance Information

____________________	____________________	__________
Primary Insurance Company	Policy/ Member ID Number	Group Number
____________________	____________________	__________
Secondary Insurance Company	Policy/ Member ID Number	Group Number

Billing/ Subscriber Information

□ If billing information is the same as above, check here. ONLY if billing and/or subscriber information is different, fill out the below information fields.

First Name ____________ MI ___ Last Name ____________ Relationship to Patient ____________

Subscriber Gender Identity:Identify as□ Male □ Female **Pronoun:** □ He/ Him □ She/Her □They/ Them

Social Security # ____________ Date of Birth ____/____/____ Email Address ____________ Cell Phone Number ____________

Daytime Phone # (if different) ____________

Address ____

City ____________________ State ________ Zip Code ____________

To the best of my knowledge, I have provided the most accurate information on this form. I will present my insurance card at every visit to ensure proper claims submissions.

Patient's Signature ________________________________ Date ____________

Kornmehl Laser Eye Associates

Medical History Questionnaire:

Patient Name ______________________________ **DOB** ____/____/_____

ALLERGIES: Medication/General	**Reaction**	**Severity**
1.______________________________	_________________________________	mild/ moderate/ severe/ fatal
2.______________________________	_________________________________	mild/ moderate/ severe/ fatal
3.______________________________	_________________________________	mild/ moderate/ severe/ fatal
4.______________________________	_________________________________	mild/ moderate/ severe/ fatal

Social History: *(Please mark all that apply, if checked circle appropriate consumption)*

□ Alcohol use ___________ □ Smoking Currently _____ packs/day Tobacco Years of Use _______ □ Former Smoker

□ No History of Smoking

Family Medical/ Ocular History: (Please list all medical and/or ocular diseases and relative)

(Ex. M/Grandmother, P/Uncle)- if more space is needed, please utilize back of the page.)

PROBLEM	**RELATIVE**	**PROBLEM**	**RELATIVE**
1. ______________________	_________________________	5. ______________________	____________________
2. ______________________	_________________________	6. ______________________	____________________
3. ______________________	_________________________	7. ______________________	____________________
4. ______________________	_________________________	8. ______________________	____________________

Ocular History *(Please mark all that apply)*

□ Overall Healthy	□ Contact Lens Wear	□ Hyperopia (Farsighted)	□ Optic Neuritis
□ Amblyopia (Lazy Eye)	□ Corneal Erosion	□ Iritis	□ Retinal Buckle
□ Aphakia	□ Diabetic Eye Disease	□ Keratoconus	□ Retinal Detachment
□ Astigmatism	□ Dry Eyes	□ Macular Degeneration	□ Trauma
□ Cataracts	□ Glaucoma	□ Myopia (Nearsighted)	□ Other ______________

Ocular Surgeries (Please mark all that apply, specify which eye and provide the date(s))

□ No prior ocular surgery	□ Foreign Body Removal	□ Punctal Plugs	□ Vitrectomy________
□ Blepharoplasty____________	□ Retinal Laser Surgery	□ RK_______________	□ Other ______________
□ Cataract Surgery___________	□ LASIK _________________	□ Strabismus/ Muscle Surgery ____________________	
□ Corneal Transplant________	□ PRK __________________	□ Trabeculectomy (Glaucoma Surgery)_____________	

Ocular Symptoms (Please mark all that apply)

□ No symptoms	□ Pain	□ Redness	□ Difficulty driving
□ Irritation	□ Discomfort	□ Intolerable Contact Lens	□ Difficulty seeing the TV
□ Burning/Stinging	□ Sandy/gritty	□ Floaters	□ Cloudy Vision
□ Excessive Tearing	□ Foreign Body Sensation	□ Flashes	□ Double Vision
□ Photophobia (Light Sensitive)	□ Painful upon awakening	□ Fluctuating Vision	□ Fatigued
□ Itchy	□ Prolonged computer use	□ Hard to open	□ Dryness
□ Ocular Migraine	□ Other: ________________	□ Metal in Eye _________	□ Rust Ring

____ _____/____/_____

Patient Signature Date

Kornmehl Laser Eye Associates

Patient Name: ____ DOB: ____/_____/______

Your Medical History(past or present) (Please check all that apply and specify if needed)

□ Acid Reflux
□ AIDS/ARC or + HIV test
□ Anemia
□ Anxiety Disorder
□ Arthritis
□ Asthma
□ Cancer: Specify ___________
□ Chest Pain
□ Coronary Artery Disease
□ Depression
□ Diabetes □ Type 1 □ Type 2
□ Emphysema/ COPD
□ Flomax (Betablocker) Past or Present
□ Gastrointestinal Disease
□ Genitourinary Disease
□ Gout
□ Headaches/ Migraines
□ Head Injury/ Concussion
□ Heart Attack
□ Heart Disease
□ Hepatitis
□ Herpes Simplex Virus □ Type 1 □ Type 2
□ High Cholesterol
□ Hypertension
□ Jaundice
□ Kidney Disease
□ Liver Disease______________
□ Lung Disease
□ Lyme Disease
□ Meningitis
□ Multiple Sclerosis
□ Neurologic Disorder
□ Psychiatric/Mental Disorder
□ Respiratory Problems
□ Seasonal Allergies
□ Seizures
□ Sleep Apnea
□ Stroke
□ Syphilis
□ Thyroid Disease
□ Tuberculosis
□ Other: __________________

Please list any other health related problems not listed above or surgical procedures you've had:

1. _______________________ 3.____________________________ 5.__________________________
2.________________________ 4.____________________________ 6.__________________________

Are you pregnant?□ Yes □ No **Nursing?** □ Yes □ No **Plan to become pregnant in the next 3-6 months?** □ Yes □ No

<u>**MEDICATION:</u>** Please list **<u>ALL</u>** medications you take whether they are prescribed or over-the-counter. Please include the name(s) of the medication, dosage, and directions. Note approximately how long you have been taking each.

Medication Name: Please print clearly	***Dosage***	***Directions***	***How Long?***
1.______________________________	__________	__________________	_________________
2.______________________________	__________	__________________	_________________
3.______________________________	__________	__________________	_________________
4.______________________________	__________	__________________	_________________
5.______________________________	__________	__________________	_________________
6.______________________________	__________	__________________	_________________
7.______________________________	__________	__________________	_________________
8.______________________________	__________	__________________	_________________
9.______________________________	__________	__________________	_________________
10._____________________________	__________	__________________	_________________

To the best of my knowledge, I have provided the most accurate information on this form. Should this information change, I will notify at each visit.

____ _____/_____/_____

Patient Signature Date