Eye Care Group

Patient Registration Information (please print)

Patient Name: _____ Gender: _____
(first) (middle) (last)

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Patient Social Security Number: _____

Home Phone: _(_____)_____ Cell Phone: _(_____)_____

Patient's Employer: _____ Employer Phone Number: _(_____)_____

Patient's Email Address: _____

Primary Care Provider (Doctor): _____ Phone Number: _(_____)_____

Marital Status (please circle): Single / Married / Divorced / Separated / Widow

Spouse Name: _____ Spouse Birthdate: _____

Responsible Party (Complete Only for Patients Under the Age of 18)

Parent/ Guardian Name: _____ Birthdate: _____

Address: _____ Social Security Number: _____

Vision Insurance Information

Insurance Company Name: _____ Policy Number: _____

Policy Holder Name: _____ Birthdate: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

Medical Insurance Information

Insurance Company Name: _____ Policy Number: _____

Policy Holder Name: _____ Birthdate: _____

Relationship to Patient: _____ Policy Holder's Employer: _____

The Eye Care Group is required by law to maintain the privacy of your health information and to provide you with a written notice of our legal duties and privacy practices with respect to that information. A copy of our policy is available on request from the receptionist who assists you during your check in and registration. We also have a copy of the policy in our waiting area and on our website, www.ecg2020.com. With the signature below, I agree that I have been given the opportunity to read and receive a copy of the Eye Care Group Notice of Privacy Practices.

Patient/ Guardian Signature: _____ Date: _____

Ocular History

Have you ever been diagnosed with the following?	Yes	No
Glaucoma		
Cataracts		
Macular Degeneration		
Amblyopia (Lazy Eye)		
Retinal Issues		
Keratoconus		

General Medical History

Have you have any of the following?	Yes	No
Hearing Loss		
Sinusitis		
Dry Mouth		
Multiple Sclerosis		
Epilepsy		
Cerebral Palsy		
Tumors		
Migraines		
Alzheimer's/ Dementia		
Depression		
Anxiety		
Bipolar		
High Blood Pressure		
Stroke		
High Cholesterol		
Heart Disease		
Vascular Disease		
Congestive Heart Failure		
Asthma		
COPD		
Emphysema		
Sleep Apnea		
Crohn's		
Colitis		
Celiac Disease		
Ulcers		
Kidney Disease		
Prostate Disease/Cancer		
Herpes		
Chlamydia		
Arthiritis		
Fibromyalgia		
Muscular Dystrophy		
Rosacea		
Melanoma		
Eczema		
Shingles		
Diabetes: What Type_____		
Thyroid Dysfunction		
Hormonal Dysfunction		

Have you had any EYE surgeries? Please list.

Date	Type of Eye Surgery

Family History

	Yes	No	If yes, what is their relationship to you?
Glaucoma			
Cataracts			
Macular Degeneration			
Amblyopia (lazy Eye)			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			

	Yes	No
Are you pregnant or nursing? Due Date_____		
Do you drink alcohol?		
Do you smoke?		

Please list all allergies.

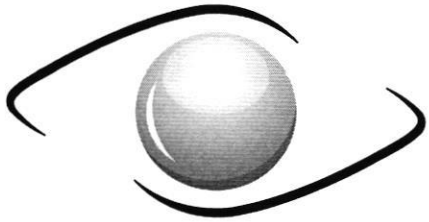
_____

_____

_____

Current Medications

Name of Medication	Dosage



eye care group

Madison, In
(812)265-6222

North Vernon, In
(812)346-8500

Vevay, In
(812)427-2717

Exam Date: _____

Child's Name: _____

I give Dr. Warner my permission to dilate my child's eyes during the eye exam.

Date: _____

Parent/Guardian Signature: _____