PATIENT REGISTRATION FORM
LANDES EYE ASSOCIATES

Date: ____ /____ /____

PATIENT INFORMATION

Last Name:_____ First:_____ Middle:_____

I prefer to be called:_____ SSN:(required)_____

Date of birth: ____ /____ /____ Age: ____ Sex: ____ [ ]single [ ]married [ ]widowed

Home Address:_____ City/State:_____ Zip:_____

Home phone:_____ Cell:_____ Work:_____

My preferred phone:_____ Is it ok to leave a detailed message on your voicemail?_____

Email:_____ Is it ok to email you?_____

CONTACTS

Emergency contact and relationship:_____ Phone:_____

If patient is a minor, name of parents:_____

Spouse name:_____ Phone:_____

Power of attorney:_____ Phone:_____

DOCTORS and PHARMACY

Referred by:_____

Primary Care Doctor:_____

Endocrinologist or other specialists:_____

Eye doctors:_____

Pharmacy name, street/city, phone:_____

Reason for visit – _____

Eye History – Please list your eye conditions, past and present, including eye surgeries, lasers, injections, eye drops, and other forms of treatment:

_____

_____

Eye drops:_____
Eye surgery:_____ When:_____ By:_____
Eye surgery:_____ When:_____ By:_____
Do you have prescription glasses?_____ If so, how old are they:_____
Do you wear glasses all the time, sometimes, or not at all:_____
Do you wear contact lenses: [ ]No [ ]Yes currently [ ]Former contact lens wearer [ ]Monovision
When was your last eye exam:_____

Medical History – Please list your medical conditions, past and present, including conditions that required hospitalization, medications, or surgery:

_____

_____

_____

Have you ever been told that you have diabetes?_____ Pre-diabetes?_____ If so, when?_____
What was your most recent Hemoglobin A1C and when:_____

Past Surgeries – Please list your surgeries/procedures and the year if known:

_____

_____

Medications – Please list your prescription and non-prescription medications and supplements, you may also attach a list: _____

_____

_____

Allergies – Please list your allergies to medications and the reaction if known, you may also attach a list. If none, write "none":

_____

_____

Family History – Please list any medical and/or eye conditions in your family:
Condition: _____ Who: _____
Condition: _____ Who: _____
Condition: _____ Who: _____

Social History
Smoking: [ ]No [ ]Yes [ ]Former
Driving status: [ ]Drives during day [ ]Drives during night [ ]No longer drive
Occupation/Place of work or Former Occupation: _____

Other
Have you had 2 or more falls within the past 12 months: [ ]No [ ]Yes