

Kay & Tabas Ophthalmology Associates

Registration Form

(Please Print)

Today's Date ____/____/____

PATIENT INFORMATION

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|---|---|---|--|
| Patient's Last Name | | First | Middle | <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. | <input type="checkbox"/> Miss <input type="checkbox"/> Ms. | Marital Status (Circle One) Single / Mar / Div / Sep / Wid | |
| Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No | If not, what is your legal name? | | (Former Name) | | Birth Date / / | Age | Sex <input type="checkbox"/> M <input type="checkbox"/> F |
| Street Address | | City | State | ZIP Code | Social Security | | Home Phone No. () |
| P.O. Box | | City | | State | | ZIP Code | |
| E-MAIL ADDRESS (to receive our informative quarterly newsletter): | | OCCUPATION: | | EMPLOYER: | | Employer Phone No. () | |
| Chose KTOA Because/Referred to KTOA by (Please check one box) | | | | <input type="checkbox"/> Dr. | <input type="checkbox"/> Insurance Plan | <input type="checkbox"/> Website | |
| <input type="checkbox"/> Family | <input type="checkbox"/> Friend | <input type="checkbox"/> Close to Home/Work | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other | | | |
| Other Family Members Seen Here _____ | | | | | | | |

Primary Physicians Name: _____ Primary Physicians Phone Number: _____
 Address: _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

| | | | | | | |
|--|----------|--|------------------------|---------|-----------------------|---------------|
| Person Responsible for Bill | | Birth Date / / | Address (if different) | | Home Phone No. () | |
| Is this person a patient here? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Occupation | Employer | Employer Address | | | Employer Phone No. | |
| Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Please indicate primary insurance _____ | | | | | | |
| Subscriber's Name | | Subscriber's S.S. # | Birth Date / / | Group # | Policy # | Co-Payment \$ |
| Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | | | | |
| Name of Secondary Insurance (if applicable) | | | Subscriber's Name | | Group # | Policy # |
| Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | | | | | |

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 authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Kay & Tabas Ophthalmology Associates or insurance company to release any information required to process my claims.

X _____
 PATIENT/GUARDIAN SIGNATURE DATE

PATIENT'S NAME: _____ DATE OF BIRTH: _____

Please list any past and present eye problems. (Describe present symptoms; list any previous eye surgery with approximate dates.)

List all **EYE** medications and describe how they are being used and in which eye:

Do you smoke? _____ If so, how much? _____
Do you drink? _____ If so, how much? _____

List any family history of eye problems (i.e. glaucoma, retinal problems, cataracts, eye muscle problems, etc.)

Do you wear glasses? _____ How long have you worn glasses? _____

How old is your present prescription? _____

Do you wear contact lenses? _____ How long have you worn contact lenses? _____

What type of lenses do you wear? _____ How old is your present prescription? _____

Are you **ALLERGIC** to any drugs or medications? (Please list names)

Do you have any of the following conditions: (all information will be confidential)

DIABETES/HOW LONG? _____ HEART PROB.? _____ HIGH BLOOD PRESSURE? _____
HIV POSITIVE? _____ Any other medical conditions? _____

| REVIEW OF SYSTEMS – Please circle if you have any of these problems. | |
|---|--|
| GI | Nausea/ vomiting/ diarrhea/ weight loss/ appetite loss/ blood in stools |
| HEART/LUNG | Asthma/ chest pain/ shortness of breath/ cough/ irregular heart beat |
| GU | Pain on urination/ blood in urine/ incontinence/ discharge |
| HEENT | Headaches/ hearing loss/ sore throat/ voice change |
| SKELETAL | Joint pain/ muscle pain/ back pain/ range of motion restriction |
| SKIN | Rashes/ bruises/ new skin lesions |
| NEURO | Headache/ blackouts/ seizures/ dizziness/ numbness or tingling |
| ENDOCRINE | Thyroid/ excessive thirst or urination/ hot or cold intolerance |

List any medications that you may be taking (other than eye medications):

List any major surgery (other than eye surgery and include approximate dates):
