

# PATIENT REGISTRATION FORM-Dr. Anil K. Sethi

Last \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Patient's Date of Birth \_\_\_\_\_

Sex: M F Age \_\_\_\_\_

**E-mail** \_\_\_\_\_

Marital Status \_\_\_\_\_

Occupation (or grade) \_\_\_\_\_

Employer (or school) \_\_\_\_\_

Whom may we contact in case of emergency?  
\_\_\_\_\_

We follow the guidelines and provisions as governed by the Health Insurance Portability and Accountability Act (HIPPA). A copy of our Privacy Practice is available in our reception area. Please initial to acknowledge our privacy policy. \_\_\_\_\_

Any problems with your current glasses and/or contact lenses? \_\_\_\_\_

Are you interested in new glasses today? Y N

**ASK US ABOUT OUR 2<sup>ND</sup> PAIR SAME DAY ORDER,**  
Backup glasses are important, consider a back up pair of readers, distance, or computer glasses, starting at \$89 complete.

Are you interested in being fit or refit for contact lenses today?  
Y N \*Fitting fees apply for contact lenses.

**VERY IMPORTANT! NEW PATIENTS ONLY:**  
Who may we thank for referring you to our office?  
Name of friend/relative: \_\_\_\_\_

How did you hear about our office? (Check all that apply.)

- Another Dr. \_\_\_\_\_
- Insurance List /Website
- Saw Sign/Building
- Web page: Which site? \_\_\_\_\_
- Other: \_\_\_\_\_

Please note that routine vision plans do not cover care for medically-related conditions.

Vision Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber SSN or ID# \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Subscriber's Address:  Same as patient

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber SSN or ID# \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Subscriber's Address:  Same as patient

Do you participate in a flex spending account?

- Yes  No

How will you settle your account today?

- Check  Credit Card  Cash

### Lifestyle Questions

Do you...

- work at a computer? How many hours/week? \_\_\_\_\_
- think you might benefit from thinner, lighter lenses?
- have an interest in being fitted for the latest contact lens designs?
- spend time outdoors? How many hours/week? \_\_\_\_\_
- have prescription sunwear? Y N Polarized? Y N
- prefer not to wear glasses at times?
- want information on LASER vision correction surgery?
- have interest in non-surgical approach to vision correction?
- have more than one pair of current Rx eyewear?
- have children? Do your children wear sunglasses? Y N
- have family members in need of eyecare?

### What activities/Sports do you engage in?

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Auto Repair</li> <li><input type="checkbox"/> Biking</li> <li><input type="checkbox"/> Boating/water sports</li> <li><input type="checkbox"/> Bookkeeping</li> <li><input type="checkbox"/> Bowling</li> <li><input type="checkbox"/> Computer</li> <li><input type="checkbox"/> Tennis/Racquetball</li> <li><input type="checkbox"/> Watching TV,movies,sport events</li> <li><input type="checkbox"/> Exercise</li> <li><input type="checkbox"/> Football</li> <li><input type="checkbox"/> Golf</li> <li><input type="checkbox"/> Gardening /Landscaping</li> <li><input type="checkbox"/> Home/shop/woodwork/carpentry</li> <li><input type="checkbox"/> Hunting Shooting</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Jogging/Running</li> <li><input type="checkbox"/> Musical instruments</li> <li><input type="checkbox"/> Painting /Drawing</li> <li><input type="checkbox"/> Playing cards</li> <li><input type="checkbox"/> Pilot/flying/Traveling</li> <li><input type="checkbox"/> Welding</li> <li><input type="checkbox"/> Reading newspapers/Books</li> <li><input type="checkbox"/> Sewing/needle work/crafts</li> <li><input type="checkbox"/> Shooting</li> <li><input type="checkbox"/> Stamp/coin collecting</li> <li><input type="checkbox"/> Swimming/Fishing</li> <li><input type="checkbox"/> Snow sports</li> <li><input type="checkbox"/> Video Gaming</li> </ul> |
|--|---|

# Medical History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Guardian (If Applicable): \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Eye Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_  
 Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Medical History

Do you have any allergies to medications?  no  yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes

Do you wear glasses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  yes  no

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

\* Please turn this form over and complete side two \*

