Accent on Eyes Patient Registration Form

Name_____Date_____

Street_____City_____State_____Zip_____

Birthdate_____ Sex ☐ M ☐ F Marital Status ☐ Married ☐ Single ☐ Other

Home Phone_____Cell Phone_____Work Phone_____

Occupation_____ Employer_____

Email_____SS#_____

Preferred Method of Contact ☐ Home ☐ Cell ☐ Email ☐ Text Message

Emergency Contact_____Relation_____Phone_____

How did you hear about our office? ☐ Previous patient of Dr. McLeod/Manello (circle) ☐ Insurance ☐ Saw building

☐ Received Mailing ☐ Family Doctor ☐ Phone book ☐ Internet ☐ Friend/Friend Name_____

Date of Last Eye Exam_____ Date of Last Medical Exam_____Physician Name_____

Do you wear glasses? ☐ Y ☐ N Contact Lenses ☐ Y ☐ N interested in Contact Lenses today? ☐ Y ☐ N

Reason for today's appointment_____

Are you using insurance for today's appointment? ☐ Y ☐ N

Vision Insurance Company_____ Medical Insurance Company_____

Primary Insured's Name_____Primary Insured's Date of Birth_____

Medical History

Family History: Eye y/n Cardiovascular y/n Diabetes y/n

Please answer yes or no to the following health conditions, mark yes to any conditions you have had in the past:

Gastrointestinal y/n **Nervous** y/n **Eyes** y/n **Endocrine** y/n **Ears/Nose/Throat** y/n **Kidney** y/n

Musculoskeletal y/n **Mental** y/n **Skin** y/n **Headaches** y/n **Allergic/Immune** y/n **Lung** y/n

Genitourinary y/n **Blood/Cardiovascular** y/n **Weight Loss/Gain** y/n **Diabetes** y/n Type ☐ I ☐ II

Please explain:_____

Do you use cigarettes/tobacco? ☐ Y ☐ N Do you use Alcohol? ☐ Y ☐ N Other Substances ☐ Y ☐ N

Medications: please list below or let us copy your list.

Medication Allergies:_____Seaonal Allergies ☐ Y ☐ N

professional services are nonrefundable. Materials may be subject to a restocking fee. Returns must be made in 45 days with a valid receipt. I certify that the above information is correct, that I accept the privacy policy of the office, and I authorize the office to bill my insurance. Any and all charges not covered by my insurance will be paid upon receipt of statement. Additionally I acknowledge receiving a copy of the privacy policy and understand the payment policy.

Signature _____**Date**_____ Doctor reviewed date _____