NORTHWEST EYE SPECIALISTS, PLLC
REGISTRATION FORM

Fishkind, Bakewell, Maltzman, Hunter & Associates
Eye Care & Surgery Center

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Race:	Ethnicity:	Language:	SSN:	Nickname:

Street Address:	Cell phone: ( )	Home phone: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. __________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Website ❑ Other

Email Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Relationship to patient:	

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group #:	Policy #:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Cell Phone ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize Northwest Eye Specialists, L.L.C., dba Fishkind, Bakewell, Maltzman & Hunter Eye Care and Surgery Center to release to the Social Security Administration & the Center for Medicare & Medicaid Services or its intermediaries or carriers any information needed for any Medicare or private insurance claim. I permit a copy of this authorization to be used in place of the original & request payment of insurance benefits be paid to Northwest Eye Specialists, L.L.C. Regulations pertaining to Medicare assignment of benefits apply.

____________________ ____________

Patient/Guardian signature *Date*

Today's Date:___________________

HEALTH HISTORY & REVIEW OF SYSTEMS

Legal Name: ____ Date of Birth: _________________

Height: _______________ Weight: _______________ Place of Birth: ____________________________

Primary Care Physician:____

Allergic to: None known Latex IV contrast dye Iodine Eggs Environmental

Medication allergies/Reaction:____

List surgeries/Year: ____

Mobility status: Ambulatory Wheelchair Walker Unable to bear weight

Do you wear contact lenses? NO YES If yes, type/brand: __________________________________

Please *circle* any condition below with which you have been diagnosed- add comments as necessary

Eyes:	no problems	glaucoma injury	cataracts	macular degeneration
Cardiovascular:	no problems	high blood pressure cardiac murmur pacemaker stent (If so, current cardiologist:____________________________)	heart attack atrial fibrillation	coronary artery disease congestive heart failure
Respiratory:	no problems	asthma lung cancer	emphysema/COPD home oxygen use	tuberculosis
Endocrine:	no problems	diabetes	thyroid disease	
Gastrointestinal:	no problems	hepatitis A/B/C/D reflux disease	liver disease colon cancer	ulcers
Genitourinary:	no problems	kidney disease prostate enlargement	dialysis prostate cancer	urinary tract infections kidney transplant
Neurologic:	no problems	stroke multiple sclerosis	seizures Alzheimer's	Parkinson's disease psychiatric (list)
Heme/Immune:	no problems	anemia bleeding disorder Other cancers (list)	leukemia lupus	lymphoma HIV/AIDS
Musculoskeletal:	no problems	rheumatoid arthritis	osteoarthritis	osteoporosis
Dermatologic:	no problems	psoriasis	eczema	rosacea
Other:	____________________________________		MRSA	

Please continue on the other side of this page...

Please *circle* any problem below which you have had *recently*

Eyes:	blurry vision, double vision, distorted vision, eye pain	Other:______________________
Ears/Nose/Throat:	ear pain, stuffy nose, sore throat, dry mouth	Other:______________________
Cardiovascular:	chest pain, palpitations	Other:______________________
Respiratory:	shortness of breath, cough	Other:______________________
Endocrine:	fatigue, hair loss	Other:______________________
Gastrointestinal:	abdominal pain, diarrhea, constipation, blood in stool	Other:______________________
Genitourinary:	painful urination, difficulty urinating, blood in urine	Other:______________________
Neurologic:	headache, weakness, numbness, imbalance	Other:______________________
Heme/Immune:	easy bruising, nosebleeds	Other:______________________
Musculoskeletal:	joint pains, poor mobility	Other:______________________
Dermatologic:	rash, sores	Other:______________________

FAMILY HISTORY- Please tell us which of your blood relatives have/had the following problems

Diabetes: __________ Heart disease: __________ High blood pressure: _________ Stroke: __________

Glaucoma: __________ Macular Degeneration: __________ Cancer (type): _________________________

SOCIAL HISTORY- Please tell us a bit about yourself

Occupation: ____

Hobbies/Interests: ____

Marital Status: Single Married Divorced Widowed

Emergency Contact: ____________________________________ Phone#: __________________________

Do you exercise? NO YES- type and frequency: ____

Do you drink alcohol? NO YES- type and frequency: ______________________________

Do you smoke tobacco? NO YES- how much? _____________ Age started: _______ Age quit: _______

Recreational drug use? NO YES- type and frequency: ____

Do you drive? NO YES

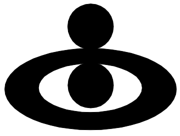
Please tell us who referred you to our practice: ____

_____________________________________ ___________________

Patient Signature: **Date:**

_____________________________________ ___________________

Signature of person other than patient completing this form **Date:**



Fishkind · Bakewell · Maltzman
Eye Care and Surgery Center

Date Reviewed	Tech	Dr
______________	_____	_____
______________	_____	_____
______________	_____	_____
______________	_____	_____

Date _______________

MEDICATION/VITAMIN LIST

Patient Name ____

Please list all medications you are presently taking.

Name of medication	Dose	How often taken

☐ I am not presently taking any medications.

____
Patient Signature