BALDWIN OPTICAL
Patient Registration

PATIENT HISTORY

First Name | Middle | Last | Date

Address | Home/Cell Phone

City | State | Zip | Work Phone

Birth Date | Age | Sex (M/F) | Insured/Responsible Party

Patient Social Security Number | Insured/Responsible Party's Social Security Number

May we leave a message for you? Y _____N ____

E-mail Address **Please tell us how we may contact you: Home/ Cell ____ Work ____ E-mail____**

Insurance Company | Member ID Number

Whom may we thank for your referral?

VISION AND HEALTH HISTORY

What is the main reason for your visit today? _____

Occupational needs _____ Hobbies _____

If you need a correction, do you want: ____ glasses ____contacts ____ Laser Vision

Have you or members of your immediate family had any of the following?

	You		Family		
	Yes	No	Yes	No	If yes, what is your relationship?
High blood pressure	___	___	___	___	_____
Heart Disease	___	___	___	___	_____
Diabetes	___	___	___	___	_____
Eye Injuries	___	___	___	___	_____
Cataracts	___	___	___	___	_____
Glaucoma	___	___	___	___	_____
Retinal detachments	___	___	___	___	_____
Lazy-eye/Amblyopia	___	___	___	___	_____

Are you currently being treated for a health condition? Yes _____ No _____
If yes, describe: _____
Are you taking medications or vitamins? Yes _____ No _____
If yes, list them: _____
Do you have any allergies, including allergies to medications? Yes _____ No _____
If yes, list them: _____

_____ **Date:** _____

Responsible Party's Signature (Sign & Print Name)