Pioneer Vision Care Patient Registration Form

Questions with an asterisk (*) are required. Please answer this form as completely as possible, print and bring this form with you to your appointment.

*** First Name :** _____ *** Last Name :** _____

*** Street Address :** _____

*** City :** _____ *** State :** _____ *** Zip Code :** _____

Home Phone : _____ *** Daytime Phone :** _____

Cell Phone : _____ **Pager Number :** _____

Fax Number : _____

Email Address : _____

*** Gender :** Male Female

*** Date of Birth (MM/DD/YYYY) :** _____

Social Security Number (At least the last 4 digits) : _____

Marital Status : Single Married Divorced Other

Employment Status : _____

Employer : _____

Occupation : _____

*** Preferred Language:** English Spanish Other

*** Race:**

___ American Indian
___ Asian
___ African American
___ Hispanic
___ White
___ Native Hawaiian or other Pacific Island
___ Other

*** Ethnicity**

___ Hispanic/Latino
___ Native Hawaiian or other Pacific Island
___ Not Hispanic/Latino

*** Communication Preference**: Email Text Phone

How were you referred to our office?

_____

* Vision History

Please select any current conditions from which you suffer.

___ Blurred Vision at Distance
___ Blurred Vision at Near
___ I do not have any complaints or concerns about my eyes
___ Headaches
___ Glare / Light Sensitivity
___ Tired Eyes
___ Amblyopia (Lazy Eye)
___ Burning
___ Dryness
___ Watery Eyes
___ Eye Pain and/or Soreness
___ Foreign Body Sensation
___ Infection of Eye or Lid
___ Itching
___ Mucous Discharge
___ Drooping Eyelid(s)
___ Redness
___ Sandy or Gritty Feeling
___ Strabismus (Crossed Eye)
___ Haloes
___ Double Vision
___ Floaters or Spots
___ Fluctuating Vision
___ Loss of Vision
___ Loss of Side Vision

If you stopped wearing contacts or glasses, please tell us the reasons.

_____

_____

Glasses History

Skip this section if you do not wear glasses.

What glasses do you own?

___ Single Vision
___ Bifocals
___ Safety Glasses
___ Backup Glasses
___ Progressive
___ Trifocals
___ Sports Glasses
___ Sunglasses
___ Other

If 'other', please enter the type of glasses: _____

How many hours a day do you use a computer? ___

How many inches away, approximately, do you sit from your computer monitor? ___

Please select any current conditions from which you suffer.

___ I am having problems with my current glasses.
___ There are times when I would rather not be wearing glasses.
___ I have problems with glare.
___ I have problems with night vision.
___ I am allergic to nickel (e.g. in frames of glasses).
___ I do not have a spare set of glasses.
___ My sunglasses are missing UV (ultra-violet) protection.

Contact Lens History

Skip this section if you do not wear contact lenses.

What brand of contact lenses do you wear? _____

How old are your current lenses? _____

How often do you replace or dispose of your contact lenses? _____

In what brand of solution do you soak your lenses? _____

How many hours per day do you wear your contacts? ___

How many days per week? ___

Please select all that apply to you.

___ I am having problems with my current contact lenses.
___ I am interested in changing or enhancing my eye color.
___ I am interested in refractive laser surgery.
___ I do not have a spare set of contact lenses.

Medical History

When, approximately, was your last eye exam? _____

Where did you get your last eye examination? _____

When, approximately, was your last physical exam? _____

Who is your Primary Care Physician? _____

Do you drink alcohol? No Yes

Do you smoke? No Yes

Please list all medical conditions that you have ever had (diabetes, high blood pressure, arthritis, etc.)

_____
_____

Please list all eye conditions you have ever had (glaucoma, cataract, wandering or lazy eye, retinal detachment, etc.)

_____

_____

Please list any medical or eye conditions that run in your family (blood relatives) such as diabetes, high blood pressure, glaucoma, macular degeneration, etc.

_____

_____

Please list all hospital surgeries you have ever had.

_____

_____

Please list all prescriptions and over-the-counter medications you take and for what conditions.

_____

_____

Please list all drug allergies you have.

_____

_____

Please select any current conditions from which you suffer.

___ Chronic fever, unexpected weight loss/gain, fatigue
___ Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat)
___ Heart problems (e.g chest pain, irregular heartbeat, swelling of feet, cold hands or feet)
___ Respiratory problems (e.g. shortness of breath, wheezing, coughing)
___ Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)
___ Genitourinary problems (e.g. painful urination, blood in urine, sex organ problems)
___ Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)
___ Skin problems (e.g. rashes, excessive dryness, growths or lumps)
___ Neurological problems (e.g. numbness, weakness, headaches, "blackouts")
___ Psychiatric problems (e.g. depression, anxiety)
___ Endocrine problems (e.g. frequent urination, thirst, feeling hot or cold all the time)
___ Blood/Lymph problems (e.g. bruising, weakness, unusual paleness, swollen glands)
___ Immune problems (e.g. frequent infections, allergic reactions to foods, dust, pollens)

Primary Insurance Information

Please bring all insurance cards with you to your appointment.

Insurance Company Name : _____
Insurance Company Phone Number : _____
Street Address : _____
City : _____
State : _____
Zip Code : _____
Insured's Name :_____

Identification Number : _____
Group Number : _____
Insured's Date of Birth (mm/dd/yyyy) : _____
Patient's Relation to Insured : _____

Secondary Insurance Information

If you have coverage through another plan/organization, please fill in the details below.

Insurance Company Name : _____
Insurance Company Phone Number : _____
Street Address : _____
City : _____
State : _____
Zip Code : _____
Insured's Name :_____
Identification Number : _____
Group Number : _____
Insured's Date of Birth (mm/dd/yyyy) : _____
Patient's Relation to Insured : _____

Health Information Protection

Your privacy is very important to us. By submitting this form, you acknowledge that you have read and agree to the HIPAA Notice of Privacy Practice that is available in our office.