MICHIANA EYE CENTER PATIENT REGISTRATION

Patient Information

Last Name_____ Social Sec #_____

First Name_____ M.I._____ Driver's License #_____

Street Address_____ Date of Birth_____/_____/_____

City_____ State_____ Zip_____ Sex: M F Marital Status: S M O

Home Phone (_____)_____ Work Phone (_____)_____

Email Address_____ Cell Phone (_____)_____

Primary Care Provider_____ Referring Provider_____

Race: *(select one)*
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ White
- ☐ Uncertain/ Decline To Answer
- ☐ Other_____(specify)

Ethnicity: *(select one)*
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Uncertain/Decline To Answer

Preferred Language: *(select one)*
- ☐ English
- ☐ French
- ☐ Spanish
- ☐ Uncertain/ Decline To Answer
- ☐ Other_____(specify)

Preferred appointment reminder method:

☐ Home Phone ☐ Cell Phone ☐ Email ☐ Work Phone

Please select one:

☐ OK to leave message ☐ Do NOT leave message

How did you hear about MEC? *(please check one)*

☐ Screening ☐ Newspaper ☐ Yellow Pages ☐ Business/Employer ☐ Insurance

☐ Radio ☐ Television ☐ Mailing ☐ Website ☐ Family/Friend ☐ Other

Parent/Spouse/Guardian Information

Full Name_____ Home Phone (_____)_____

Relationship to Patient_____ Date of Birth_____/_____/_____

Address_____ City_____ State_____ Zip_____

In an emergency, who may we contact that does **not** live at this address?

Name_____ Phone (_____)_____ Relationship_____

Privacy laws allow only the person listed to be given medical information without the patient's permission.

Past History

Are you being treated for any current eye conditions?_____

List all the eye surgeries and eye injuries you have had in the past:_____

_____

List all medications you take:

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If "Yes", please list medications and reactions:_____

	YES	NO
Do you drive?	☐	☐
Problem with night vision?	☐	☐
Do you currently wear glasses?	☐	☐
Are you a current contact lens user?	☐	☐

	YES	NO	
Do you drink alcohol?	☐	☐	How many drinks a day?____
Do you smoke cigarettes?	☐	☐	

How often do you smoke?

- ☐ Current Everyday Smoker
- ☐ Occasional Smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Uncertain/ Decline to Answer

Patient*/Parent/Guardian _____ _____/_____/____

Signature Date

*Must be signed by parent or guardian if patient is a minor.

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