OPHTHALMIC CONSULTANTS OF LONG ISLAND: REGISTRATION FORM (PLEASE PRINT)

PATIENT INFORMATION				
Patient's Name (First name Middle name Last name):				❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr.
Email Address:	Social Security No.:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Home phone: ( )	Cell phone: ( )		
City:	State:	Zip:		
Occupation:	Employer:	Employer phone: ( )		

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)			
Name (First name Middle name Last name):	Social Security no.:	Birth date: / /	Sex: ❑ M ❑ F
Street address:	City:	State:	ZIP Code:
Relationship to Patient:	Home phone: ( )	Cell phone: ( )	

INSURANCE INFORMATION	
Name of PRIMARY Insurance & ID#:	Name of SECONDARY Insurance & ID#:

PRIMARY CARE PHYSICIAN (PCP)		
Name:	Address:	Phone: ( )

OPTOMETRIST (OD)		
Name:	Address:	Phone: ( )

REFERRING DOCTOR (OTHER THAN PRIMARY CARE PHYSICIAN & OPTOMETRIST)		
Name:	Address:	Phone no: ( )

IN CASE OF EMERGENCY			
Emergency Contact (Not living at same address):	Relationship:	Home phone: ( )	Work phone: ( )

ARE YOU INTERESTED IN? (PLEASE CHECK **ALL** APPROPRIATE BOXES)		
❑ Decreasing Your Need for Reading Glasses	❑ LASIK	❑ Cosmetic Options: Botox, Dermal Fillers, Eyelid Lifts, Etc

HOW DID YOU HEAR ABOUT OCLI? (please check **ALL** appropriate boxes):			
❑ Family/Friend (please specify person)	❑ Dr. (please specify doctor)	❑ Website (please specify site)	❑ Insurance Plan
❑ Radio (please specify radio station)	❑ Newspaper Ad (please specify paper)	❑ Yellow Pages	❑ Other (please specify other)

PHARMACY			
Name:			
Address:	City:	State:	Zip:

Patient Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: **DOB:** **Location:**

Reason for today's visit: _____

_____

List ALL Medications,Supplements / Vitamins you currently take, including eyedrops/ ointments:_____

_____

_____

_____

List any **OCULAR** surgery, laser, trauma: _____

_____

List any other hospitalizations/surgeries that you have had:_____

_____

List any other problems with your eyes: NONE ☐

(Type) Contact Lens Wear for years -Dispose of every days/ weeks/ month

Medical & Social History

Allergy to medication Yes / No if so give details:

Have you ever had any reaction to anesthesia? **Yes / No**

Do you drink alcohol? **Yes / No** How much?

Do you smoke? **Yes / No** How much?

	Yes	No	STAFF USE ONLY PROVIDE DATES AND DETAILS
GENERAL / CONSTITUTIONAL (fever, heatstroke, weight loss, weight gain, unusually tired, serious childhood illness, etc.)	☐	☐	
EARS, NOSE, THROAT (hard of hearing, congestion, earache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR (pacemaker, defibrillator, High BP, racing pulse, etc.)	☐	☐	
RESPIRATORY (congestion, wheezing, short of breath,etc.)	☐	☐	
GASTROINTESTINAL (stomach upset, diarrhea,constipation, hernia, ulcers, etc.)	☐	☐	
GENITAL,KIDNEY,BLADDER (painful urination, frequent urination, impotence, yellow jaundice, prostate problems,etc.)	☐	☐	
FEMALES Are you pregnant? Nursing?	☐	☐	
MUSCLES, BONES, JOINTS (joint pain, stiffness,swelling, cramps, arthritis, etc.)	☐	☐	
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	
NEUROLOGICAL (numbness, headache, seizure, paralysis, loss of consciousness, etc.)	☐	☐	
ALLERGIC / IMMUNOLOGIC(sneezing,swelling, redness, itching, hives, Lupus, Sjogrens etc.)	☐	☐	
PSYCHIATRIC (Anxiety, Depression, Insomnia)	☐	☐	
BLOOD / LYMPH (Bleeding, Cholesterolemia, anemia, problems related to blood transfusion, etc.)	☐	☐	
CANCER (Site)	☐	☐	
ENDOCRINE (Diabetes, Hypothyroid, etc.) Insulin ☐ NonInsulin ☐	☐	☐	
Last blood sugar level Date taken			

Circle any of the following diseases your family members have been diagnosed with: **NONE** **UNKNOWN**

Blindness/ Cataract/ Glaucoma/ Diabetes/ Hypertension/ Heart Disease/ Stroke/ Cancer/ Thyroid Disease/ Arthritis

Other disease:

Patient Signature: _____ **Date:** _____