OCLI

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 no.: ( )	Cell phone no.: ( )		
City:	State:	Zip:		
Occupation:	Employer:	Employer phone no.: ( )		

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 no.: ( )	Cell phone no.: ( )	

INSURANCE INFORMATION

Name of **PRIMARY** Insurance, **ID#**& **Subscriber if different from self:**	Name of **SECONDARY** Insurance , **ID#**& **Subscriber if different from self:**

Primary Care Physician (PCP)

Name:	Address:	Phone no.: ( )

Referring Doctor (Other than Primary Care Physician & Optometrist)

Name:	Address:	Phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

ARE YOU INTERESTED IN? (please check **ALL** appropriate boxes)

☐ Decreasing Your Need for Reading Glasses ☐ LASIK ☐ Cosmetic Options: Botox, Dermal Fillers, Eyelid Lifts, Etc

PHARMACY

Name:			
Address:	City:	State:	Zip:
Phone #:	Fax #:		

Patient Signature:_____ Date:_____

833-509-OCLI
(833-509-6254)

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Patient Name: **Date of Birth:** **Date:**

Reason(s) for today's visit:	
Who is your Primary Care Physician (PCP)?	
Do you currently see any other doctor/specialist for other medical conditions? Yes / No	
List any medical condition(s) you have: _____ _____	**Past Medical History**
List any hospitalizations and/or surgeries with date(s): _____ _____	
List any EYE surgery with date(s): _____ _____	
List your prescribed medication(s), including vitamins/supplements: o No Current Meds _____ _____	
List known allergies (including medication allergies) and reaction: o None Known Allergies (NKA) _____	
Have you ever had a reaction to anesthesia? o Yes o No	
Do you use tobacco? o Yes o No **Year Quit, if applicable**:	**Social History**
Do you consume alcohol? o Yes o No **Drinks per week:**	
What is your occupation?	
Do you have relatives with: o Blindness o Cataract(s) o Glaucoma o Diabetes oHypertension o Heart Disease o Stroke o Cancer oThyroid Disease o Arthritis o Other _____ o Unknown	**Family History**

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Patient Name: **Date of Birth:** **Date:**

Are you currently experiencing any of the following? If yes, circle:	**YES**	**NO**	
GENERAL/CONSTITUTIONAL: fever, heatstroke, weight loss, weight gain, fatigue, other			**Review of Systems**
EYES: blurry vision, dry eyes, floaters, light sensitivity, discharge, pain, other			
EAR, NOSE, THROAT: hard of hearing, congestion, earache, cough, dry mouth, other			
CARDIOVASCULAR: pacemaker, defibrillator, high or low blood pressure, racing pulse, other			
RESPIRATORY: congestion, wheezing, short of breath, other			
GASTROINTESTINAL: stomach upset, diarrhea, constipation, hernia, ulcers, other			
GENITOURINARY: painful/frequent urination, kidney disease, prostate problems, other			
FEMALES: pregnant, nursing			
MUSCULOSKELETAL: joint pain, stiffness, swelling, cramps, arthritis, other			
SKIN: pimples, warts, growths, rash, other			
NEUROLOGICAL: numbness, headache, seizure, paralysis, loss of consciousness, other			
ALLERGIC/IMMUNOLOGIC: redness, itching, hives, Lupus, Sjogren's, other			
PSYCHIATRIC: anxiety, depression, insomnia, other			
BLOOD/LYMPH: bleeding, cholesterolemia, anemia, problems with blood transfusion, other			
CANCER:			
ENDOCRINE: Type I Diabetes, Type II Diabetes, hypothyroid, other ☐ Insulin ☐ Non-Insulin Last blood sugar level Date taken			

Do you wear glasses for distance? o Yes o No **Do you wear reading glasses?** o Yes o No

Do you wear contact lenses? o Yes o No

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

Patient Signature: _____ Date: _____ Doctor Initials: _____