PATIENT REGISTRATION QUESTIONNAIRE

Name _____ Birthdate ___/___/___ Sex: M F Phone (Home)_____

(Cell)_____

Address _____ City _____ State _____ Zip Code _____

MARITAL STATUS: S M W D Spouse's Name or Nearest Relative _____

Occupation _____ Employed By: _____ Work # _____

SS#_____ Whom May We Thank for Referring You?_____

Is your visit today for a routine eye exam or a problem? If problem, please describe. _____

_____

MEDICAL HISTORY

Name & Address of Family Physician _____

HAVE YOU HAD: Please circle YES or NO

DIABETES	YES	NO	PROLONGED BLEEDING	YES	NO
HEART DISEASE	YES	NO	CIRCULATORY PROBLEMS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	SURGERY:_____		
RHEUMATIC FEVER	YES	NO	_____		
RESPIRATORY DISEASE	YES	NO			
HEPATITIS	YES	NO	OTHER:_____		

ROS: (Present Problems) ☐ HEART DISEASE ☐ LUNG DISEASE ☐ STOMACH, INTESTINE, ETC.

Please ✓ ☐ KIDNEY/URINARY TRACT ☐ NEUROLOGICAL

Social History ☐ SMOKER: PACK/DAY_____ ☐ ALCOHOL: FREQUENCY_____

If you ✓'d any of the above, please explain on back.

Are you seeing a physician for these problems? _____

Please list all medications you are currently taking: _____

Resident: ☐ PERMANENT ☐ SEASONAL _____

EYE HISTORY

Please place an X next to conditions you have had in the past.

____ CATARACT	VISION LOSS	____ IRITIS
____ CATARACT SURGERY	____ TOTAL	____ CONTACT LENSES
____ GLAUCOMA	____ PARTIAL	____ OTHER: Please describe
____ RETINAL TEARS	____ INJURIES	_____
____ RETINAL DETACHMENTS		_____

Please list any medications you are taking for your eyes. _____

_____

Family History: ☐ CATARACTS ☐ GLAUCOMA ☐ MACULAR DEGENERATION

☐ DIABETES List details:_____

Are you allergic to: ☐ PENICILLIN ☐ NOVACAINE ☐ ZYLOCAINE ☐ ASPIRIN ☐

OTHER _____

Patient Signature ✖ _____ **Date** _____

E-MAIL _____

Cataract & Refractive
INSTITUTE OF FLORIDA

James E. Croley III, M.D.

Board Certified Ophthalmologist

Notice of Privacy Practice

You have the right to obtain a paper copy of this notice from us upon request.

Name:_____Date:_____DOB:_____Account #_____

Release of Information

Do you authorize the release of appointment information, medical and financial claims information? _____Yes_____No

If yes, this information may be released to the individual(s) listed below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

This release of information will remain in effect until terminated by me in writing

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- Other:_____

When leaving message:

Please call

- My Home
- My work
- My cell

Number:_____-_____-_____ Ext:_____

The best time to reach me is (day)_____between (time)_____and_____

Patient Signature_____Date:_____