SEC # _____
(OFFICE USE ONLY)

Stingl Eye Clinic Patient Registration Form

How did you hear about us? Phonebook/Internet / TV /Newspaper_____

Family / Friend / Insurance Plan / Hospital / Doctor Referral /By Whom? _____

Your Primary Physician's Name: _____

Your Last Name: _____ First: _____ MI:_____

Age: _____ DOB: _____ SSN: _____ Sex: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____May we leave messages on your answering machine? Y / N

Cell Phone: _____E-mail address: _____

Work Phone: _____ Your Occupation: _____

Spouse's name: _____Spouse's Occupation: _____

Do you give us permission to advise family of your medical status? Y / N Date and initial: _____

Whom do we call in case of an emergency? _____

Phone: _____ Relationship to you: _____

IF PATIENT IS A MINOR OR HAS A LEGAL CUSTODIAN, THE RESPONSIBLE ADULT IS:

Last Name: _____ _____First Name: _____

DOB: _____ SSN: _____

Street: _____City: _____State: ___ _____Zip: _____

Home Phone: _____Cell Phone: _____ E-mail address: _____

*The following demographics information requested is for insurance and EMR (Electronic Medical Records) purposes that can be helpful as some diseases are more relevant in certain races or ethnicities, which can be important to patient care. Please circle what applies to you. **You also have the right to decline giving this information**.

Race: White - Black/African American – Asian – American Indian or Alaskan Native – Native Hawaiian or Pacific Islander

Ethnicity: Hispanic, Latino or Spanish Origin or NOT Hispanic, Latino, or Spanish Origin

Preferred Language: English/Spanish/other (please note: _____)

Decline to Answer: _____ Initial

Updated 2/1/2017

SEC # _____
(OFFICE USE ONLY)

Patient History

What is the main reason for your visit today? _____
_____

PAST EYE HISTORY/SURGERY: Have <u>you OR any family members</u> ever had any of these <u>eye PROBLEMS</u>? N/Y

	Self	Family		Self	Family
Cataract:	____	____	Serious eye injury (e.g., black eye):	____	_____
Iritis/uveitis:	____	____	Poor vision / Lazy eye (Strabismus and/or Amblyopia):	____	_____
Glaucoma:	____	____	Eye not straight (Strabismus):	____	_____
Diabetic eye disease:	____	____	Wore an eye patch as a child (Amblyopia):	____	_____
Macular Degeneration:	____	____	Blindness/Loss of eye(s):	____	_____
Retinal Detachment:	____	____	**Eye surgery (including laser):** _____		

Other:_____

Have <u>you OR any family members</u> ever had any of these <u>eye SYMPTOMS</u>? NO/YES (check all that apply):

	Self	Family		Self	Family
Red Eyes:	____	_____	Blurred distance vision (e.g., driving):	____	_____
Dry Eyes:	____	_____	Blurred intermediate vision (e.g., computers):	____	_____
Itching/burning eyes:	____	_____	Blurred near vision (e.g., reading):	____	_____
Mattering/tearing:	____	_____	Glare, halos, star-bursts around lights:	____	_____
Foreign body sensation:	____	_____	Problems with driving:	____	_____
Eye pain:	____	_____	Problems with night vision:	____	_____

Other: _____

GLASSES / CONTACT LENSES

Wear Glasses? No / Yes What % of the time? _____ How old are the glasses? _____
Contact lenses? No / Yes What % of the time? _____ How old are the contacts? _____
Any Problems? No / Yes What: _____
Last eye exam? _____ Where: _____
Are you interested in getting a new prescription (refraction) for <u>*glasses*</u> ? No / Yes
Are you interested in getting a new prescription (refraction) for <u>*contact lenses*</u> ? No / Yes

MEDICATIONS

List all <u>eye drops /medication</u>:

<u>Name</u>	<u>Dosage</u>	<u>Times per day</u>	<u>Which eye</u>	<u>Compliance(Y/N)</u>
_____	_____	1 2 3 4	right left both	_____
_____	_____	1 2 3 4	right left both	_____
_____	_____	1 2 3 4	right left both	_____

List all <u>*systemic medications*</u> (not involving the eyes):

Medication Name	Dosage Amount	(Schedule) Times per day	Admin Route	For what condition	Compliance (Y/N)
_____	_____	1 2 3 4	_____	_____	_____
_____	_____	1 2 3 4	_____	_____	_____
_____	_____	1 2 3 4	_____	_____	_____
_____	_____	1 2 3 4	_____	_____	_____
_____	_____	1 2 3 4	_____	_____	_____

Do you have any intolerances or allergies (to medications or otherwise)? NO/ YES (list below)

<u>Medication Name</u>	<u>Reaction</u>: Allergy (hives/swelling/anaphylaxis) vs. Intolerance (rash, GI upset, side effects)
_____	_____
_____	_____

SEC # _____
(OFFICE USE ONLY)

Medical-- List physicians involved in your care: _____

Pharmacy (Name & Location): _____ Phone: _____

Do <u>you OR a family member</u> have/ had any of these medical conditions? NONE / YES (check):

	Self	Family		Self	Family		Self	Family
AIDS/HIV	____	____	Dizziness (Vertigo)	____	____	Intestinal problems	____	____
Hay Fever	____	____	Depression	____	____	Lung Diseases	____	____
Anemia	____	____	Reflux/heartburn	____	____	Lupus	____	____
Anxiety	____	____	Gout	____	____	Sjogren's syndrome	____	____
Arrhythmia	____	____	Headaches/Migraines	____	____	Stroke	____	____
Arthritis	____	____	Heart Disease	____	____	Thyroid disease	____	____
Asthma	____	____	Hepatitis	____	____	Tuberculosis	____	____
Cancer	____	____	High Blood Pressure	____	____			
Diabetes	____	____	High Cholesterol	____	____			

Review of Systems: Do you have any of these symptoms? Please specify.

Allergy (runny nose, sneezing, allergy symptoms):_____
Cardiovascular (chest pains): _____
General (weight loss, loss of appetite): _____
Endocrine (weight loss or gain): _____
Gastrointestinal (nausea, vomiting, diarrhea): _____
Genitourinary (discomfort with urination): _____
Blood (easy bleeding, bruising): _____
Head/Ears/Nose/Throat (sinus problems, ear pain):_____
Infectious Disease (lesions):_____
Skin (rash, sores, acne):_____
Musculoskeletal (arthritis, sore muscles):_____
Neurologic (headaches, double vision):_____
Psychiatric (depression, anxiety, mood swings):_____
Breathing (shortness of breath, sleep apnea):_____
Other: _____

What medical illnesses or conditions required a <u>hospital stay</u>?

<u>Illness or Condition</u>	**<u>Date/year (or your age)</u>**
_____	_____
_____	_____

List any <u>surgeries</u> (not involving the eyes):

<u>Type of surgery</u>	**For what condition**	**<u>Date/year (or your age)</u>**	**<u>Surgeon (if known)</u>**
_____	_____	_____	_____
_____	_____	_____	_____

Social:

Marital status:	Married	Divorced	Single	Widowed	Separated
Smoking:	Non-smoker	Smoker	Ex-Smoker	Packs/Day: ___	# of years: _____
Alcohol:	None	Unknown	Social/Occ.	Daily	amount/day: _____
Drug use:	None	Unknown	Recreational	IV drug abuse	Type: _____

Optional: Please tell me one unique or interesting thing about you: _____
_____

Updated 2/1/2017

SEC # _____
(OFFICE USE ONLY)

CONSENT FOR TREATMENT/CONSENT FOR FILING INSURANCES

I HEREBY AUTHORIZE the Stingl Eye Clinic to examine and treat me or the individual for whom I am responsible. Initial: _____

I AUTHORIZE the Stingl Eye Clinic to release information acquired in the course of my examination and treatment to my insurance carriers. Initial: _____

I FURTHER UNDERSTAND that I have primary responsibility for payment of my charges. Initial: _____

Consent for the use of dilating eye drops

Dilating eye drops are used to enlarge the pupils, allowing our physician to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating eye drops will usually cause blurred vision. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired as a result, varies from person to person. It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.

Driving, even in low-light conditions, may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

I _____(Patient Name)
hereby authorize Dr. Daniel Stingl and/or his assistants
to administer dilating eye drops during the course of my treatment. Initial: _____

I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated; or by wearing sunglasses while driving. I further understand that should I decline having my eyes dilated for an exam, that certain conditions may not be discoverable by my doctor and I hereby release Dr. Daniel Stingl and the Stingl Eye Clinic of any liability.

Initial: _____

Patient (or patient's authorized representative): **X** _____

Signature of Patient (or guardian)

X _____

Printed Name

Updated 2/1/2017