*** Please fill out this form and email to info@fromereye.com or print and bring it to your appointment ***

Fromer Eye Centers **REGISTRATION FORM**

Today's Date: ____________________

Last Name ____________ First Name ____________ MI ____________

Mr. _____ Mrs. _____ Ms. _____ Dr. _____

Race: [ ] African American [ ] Asian [ ] Caucasian [ ] Hispanic [ ] Native American [ ] Other ________

Male _____ Female _____

Date of Birth ____________ Age ______

Ethnicity: ____________________

Primary Language: ____________________

Social Security Number ____________________

E-Mail Address ____________________

Pharmacy Name: ____________________

Street Address ____________________

Pharmacy Address: ____________________

____

Apartment Number ____________________

Pharmacy Telephone: ____________________

City ____________ State ______ Zip Code ________

Contact Preference for Healthcare Reminders Phone Email

Primary Phone ____________________

Secondary Phone ____________________

Occupation/Employer ____________________

Work Phone Number ____________________

Primary Care Physician's Name (PCP) (REQUIRED) ____________________

PCP's Address ____________________

PCP's Telephone Number ____________________

Referring Physician: ____________ *First Name* ____________ *Last Name* ____________ *Address/ Telephone Number*

In case of an emergency, please contact:

Name of Person ____________________

Relationship to you ____________________

Contact's Primary Phone ____________________

Contact's Secondary Phone ____________________

Legal Guardian: ____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Fromer Eye Centers or insurance company to release any information required to process my claims. Payment is expected at the time of the visit unless we participate with your insurance plan. Any copayment required under your plan is due at time of visit. I have received the Notice of Privacy Practices and I have had an opportunity to review it, and take a copy for my records.

____________________ **PATIENT/GUARDIAN SIGNATURE**

____________________ **DATE**

Pediatric Ocular and Medical History Questionnaire	Account#

Patient's Name:		Date of Birth		Todays Date:	
Race/Ethnicity	☐ Hispanic or Latino	☐ White	☐ Black or African American	☐ American Indian	☐ Asian
☐ Hawaiian or other Pacific Islander	Other (Specify):				
Who can we thank for referring you?					
Name:	Address:				
The reason my child is being examined is					
Last eye exam		Where:	Glasses: ☐ YES ☐ NO Age 1st worn		

Does your child have any of the following:			Explain :
Eye turns in/out	☐ Yes	☐ No	
Any lazy eye/amblyopia	☐ Yes	☐ No	
Squints a lot	☐ Yes	☐ No	
Doesn't seem to focus	☐ Yes	☐ No	
Rubs eyes excessively	☐ Yes	☐ No	
Burn, itch, red, tearing, discharge	☐ Yes	☐ No	
Head tilt/Face turn	☐ Yes	☐ No	
Frequent Headaches	☐ Yes	☐ No	
Eye Pain	☐ Yes	☐ No	
Excess light sensitivity	☐ Yes	☐ No	
Any eye injury or surgery	☐ Yes	☐ No	
Child's doctor:	Last Exam Date:		Are immunizations up to date: ☐ Yes ☐ No

Birth and Development History							
How long was the pregnancy?		Months	Birth weight		lbs		oz
Any complications during pregnancy?	☐ Yes	☐ No	If yes, explain				
Any complications during delivery?	☐ Yes	☐ No	If yes, explain				
Any complications after birth?	☐ Yes	☐ No	If yes, explain				
Age when child first:	Sat		Crawled		Walked		Talked (2-3 words)

Academic History								
What grade is your child in?		Is your child in any special classes?				☐ Yes	☐ No	
Is your child below grade level for reading?		☐ Yes	☐ No					
Has your child undergone any of the following testing/ treatment?					See below			
Educational	☐ Yes	☐ No	Neurological	☐ Yes	☐ No	Psychological	☐ Yes	☐ No
Occupational	☐ Yes	☐ No	Speech	☐ Yes	☐ No	Physical	☐ Yes	☐ No

Medication History/System Review	Yes	No	Explain
Cardiovascular problems (high blood pressure, murmur)	☐	☐	
Breathing problems (Asthma, shortness of breath, other	☐	☐	
Endocrine Problems (Diabetes, thyroid, growth, other)	☐	☐	
Skin Problems (rashes, excess dryness, other)	☐	☐	
Neurological problems (High fever, seizures, balance, other)	☐	☐	
Psychiatric/Social problems(Any behavior problems, other)	☐	☐	
General Growth/developmental: normal or delayed	☐	☐	

Family History	Yes	No	Who:	Explain
Amblyopia/Lazy eye	☐	☐		
Eye Turn/Strabismus	☐	☐		
Myopia/Hyperopia as young child	☐	☐		
Color Vision defect	☐	☐		
Glaucoma	☐	☐		
Cataracts before age 40	☐	☐		
Blindness	☐	☐		

Patient ID:

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. It is also important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

By signing this consent form you consent to allow us to access your medication history selected, you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan.

You may decide not to allow us to access any of your medication history by making the checkbox not consent us to access any of your medication history. By checking this option you are also agreeing that we can’t provide electronic prescriptions as well.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

☐ **I consent to allow my provider access to my medication history.**

☐ **I DO NOT consent to my provider access to any of my medication history.**

________________________________ **Print Patient Name** ____________________ **Patient DOB**

________________________________ **Signature of Patient or Guardian** ____________________ **Today’s Date**

________________________________ **Relationship to Patient**