**** 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

Mr. ____ Mrs. ____ Ms. ____ Dr. ____

Male ______ Female ______

MI

Race: [ ] African American [ ] Asian [ ] Caucasian

[ ] Hispanic [ ] Native American [ ] Other ________

Ethnicity: ____________________

Primary Language: ____________________

Date of Birth

Age

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

AUTHORIZATION TO TREAT A MINOR

To be completed by parent/guardian

Date: ______________________________

Patient Name: ______________________________

Patient Date of Birth: ______________________________

Guardian Name: ______________________________

Relationship to Patient: ______________________________

Emergency Contact #: ______________________________

Account #: ______________________________

MEDICAL CARE AUTHORIZATION

I, ______________________________, the parent or guardian of patient

______________________________ , authorize Fromer Eye Centers and any member of its staff to provide medical care to my dependent for the period of one year from the date of this letter. I understand that I am fully responsible financially for the patient's co-pays, coinsurance, and anything not covered by the insurance.

______________________________ ______________________________

Guardian Name **Guardian Signature**

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**