Patient Registration/History

Patient's Name: _____ Sex: ☐ Male / ☐ Female

Address: _____ Date of Birth: _____

City/State/Zip:_____ SSN#: _____

Home Phone: _____ Work Phone: _____ Alternate Phone: _____

Employer/School: _____ Occupation: _____ Marital Status: _____

How did you hear about our office? _____ Spouse/Guardian: _____

Whom may we thank for referring you? _____ E-Mail:_____

ASSIGNMENT and RELEASE
I authorize Dr. Joseph E. Droter, O.D. to release medical information about me to Medicare and/or other insurers to determine benefits. I give permission for all Medicare and other insurance payments to be made payable to Dr. Joseph E. Droter, O.D. for all medical care and optometric services, and I understand that I am financially responsible for non-covered services. *I acknowledge that I received a copy of the Joseph E. Droter, O.D., P.C. Notice of Privacy Practices.*

RESPONSIBLE PARTY SIGNATURE: _____ Date: _____

Medical History	**Ocular History**
List any Medications you are taking:	Do you wear glasses? Y ☐ N ☐
	How old is the prescription?
	Do you wear contact lenses? Y ☐ N ☐
	If yes, what brand/type?
	Problems with contacts? Y ☐ N ☐
	Are you interested in contact lenses? Y ☐ N ☐
List any allergies you have:	Are you interested in Laser Vision Correction? Y ☐ N ☐
	Social History
	Do you drive? Y ☐ N ☐
List all major illnesses, surgeries, hospitalizations:	If yes, explain any visual difficulties when driving:
	Do you: Type/Amount
	Use tobacco products? Y ☐ N ☐
Are you pregnant or nursing? Y ☐ N ☐	Drink alcohol? Y ☐ N ☐
Family Physician:	Use illegal drugs? Y ☐ N ☐
Last Medical Exam:	Have you been exposed to a sexually transmitted disease? Y ☐ N ☐
Last Eye Exam:	

Payment is due when services are rendered. A 5% finance charge will be applied to any account 30 days past due.