MICHIANA EYE CENTER
& FACIAL PLASTIC SURGERY

PATIENT REGISTRATION

Date_____/____/_____

Patient Information

Last Name_____ Social Sec #_____
First Name_____ M.I._____ Driver's License #_____
Street Address_____ Date of Birth_____/_____/_____
City_____ State_____ Zip_____ Sex: M F Marital Status: S M O

Home Phone (_____)_____
Work Phone (_____)_____
Cell Phone (_____)_____
Email Address_____

Preferred appointment/follow-up reminder method
☐ Home Phone ☐ Cell Phone
☐ Work Phone ☐ Email
Please select one:
☐ OK to leave message ☐ Do NOT leave message

Race: *(select one)*
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ White
☐ Uncertain/ Decline To Answer
☐ Other_____(specify)

Ethnicity: *(select one)*
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Uncertain/ Decline To Answer

Preferred Language: *(select one)*
☐ English
☐ French
☐ Spanish
☐ Decline To Answer
☐ Other_____(specify)

How did you hear about MEC? *(please check one)*
☐ Insurance ☐ Family/Friend ☐ Doctor
☐ Screening ☐ Newspaper ☐ Yellow Pages ☐ Business/Employer ☐ Website
☐ Radio ☐ Television ☐ Mailing ☐ Other_____(specify)

Parent/Spouse/Guardian Information

Full Name_____ Social Sec #_____
Relationship to Patient_____ Date of Birth_____/_____/_____
Address_____ City_____ State_____ Zip_____
Employer_____ Home Phone (_____)_____
In an emergency, who may we contact that does **not** live at this address?
Name_____ Phone (_____)_____ Relationship_____
Privacy laws allow only the person listed to be given medical information without the patient's permission.

Health Information

Family Physician_____ Phone # or Name of Practice_____
Referring Physician_____ Phone # or Name of Practice_____
Preferred Pharmacy_____ Phone, Street or Nearest Intersection_____

Do you presently have any problems in the following areas? If "Yes", please give an explanation:

		Yes	No	Explanation
Eyes:	Decreased, Blurred or Distorted Vision?	☐	☐	_____
	Loss of Side Vision?	☐	☐	_____
	Double Vision?	☐	☐	_____
	Burning, Itching, or Dry Eyes?	☐	☐	_____
	Mucous Discharge or Redness?	☐	☐	_____
	Eye Pain?	☐	☐	_____

Health Information *(continued)*

Are you being treated in any of the following areas? If "Yes", please give an explanation:

		Yes	No	Explanation
Ear/Nose/Throat:	Sinus congestion or allergies?	☐	☐	
	Recent sore throat or runny nose?	☐	☐	
Cardiovascular:	Heart condition/blood vessels?	☐	☐	
	Hypertension/Arteriosclerosis?	☐	☐	
	Diabetes?	☐	☐	
Respiratory:	Lungs/Breathing/Asthma?	☐	☐	
Gastrointestinal:	Stomach/Intestines?	☐	☐	
Genitourinary:	Genital/Kidneys/Bladder?	☐	☐	
Other:	Muscle or Joint Pain?	☐	☐	
	Skin Conditions?	☐	☐	
	Neurological?	☐	☐	
	Thyroid Problems?	☐	☐	
	Blood or Lymph Node Problems?	☐	☐	

Past History

Are you being treated for any eye conditions?_____

List all the eye surgeries and eye injuries you have had in the past:_____

_____

List all medications you take:

_____

Do you have any allergies to any medications? ☐ Yes ☐ No

If "Yes", please list medications:_____

Family History

	Yes	No	Relationship to Patient
Blindness or Cataracts?	☐	☐	
Macular Degeneration?	☐	☐	
Glaucoma?	☐	☐	
Retinal Detachment?	☐	☐	
Arthritis, Lupus or Sjorgren's Syndrome?	☐	☐	
Diabetes?	☐	☐	
Hypertension?	☐	☐	
Thyroid Disease?	☐	☐	
Cancer?	☐	☐	

Social History

Current Occupation:_____

	Yes	No
Do you drive?	☐	☐
Problem with night vision?	☐	☐
Do you currently wear glasses?	☐	☐
Are you a current contact lens user?	☐	☐

	Yes	No
Do you drink alcohol?	☐	☐

If "Yes", how many drinks a day?_____

	Yes	No
Do you smoke cigarettes?	☐	☐

How often do you smoke?

☐ Current Everyday Smoker ☐ Current Someday Smoker

☐ Former Smoker ☐ Never Smoker

☐ Decline to Answer

Patient / Guardian_____(print) _____*(signature)*

First, MI, Last and Suffix *First, MI, Last and Suffix*