TIMPANOGOS VISION CENTER
Patient Registration

Last Name________________________________First Name________________________________Middle Initial_______________

Address____City_________________________State_________Zip_______________

Home Phone#____________________Work #____________________Cell#__________________Birth Date_____/_____/_____

Sex: Male _____ Female _____ Age:_____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Whom do you want listed as head of household?_______________________________Relationship to Patient:__________________

How did you find out about our office?____

What is the main reason for today's visit?____

Insurance Information

Vision Insurance Co:___________________________ID#______________________Medical Insurance Co:____________________

Name of Insured:__________________________ Patient Relationship to Insured:____

Eye Health Information

Do you currently wear glasses?____Yes____No If yes, are they single vision, bifocal, trifocal, progressive, or reading?________
Do you currently wear contact lenses?____Yes____No If no, are you interested in contact lenses? Yes____No____

Are you currently experiencing any of the following symptoms?

___Blurred Vision
___Foreign Body Sensation
___Redness
___Flashes/Floaters
___Loss of Side Vision
___Burning
___Itching
___Glare/Light Sensitivity
___Mucous Discharge
___Double Vision
___Stinging
___Excess Tearing/Watering
___Eye Pain/Soreness/Irritation
___Distorted Vision
___Difficulty Focusing

Have you ever had any eye injuries or been diagnosed with any type of eye disease? No____Yes_______________________________

Have you had any eye surgeries? No___Yes___ If yes, type of surgery and date:____

Review of Systems

Do you currently or in the recent past had problems in the following areas *(Note: This information is important to the doctor as many health problems can affect the eyes. Also, if we are billing any kind of insurance for you, we are required to have this information).*

____Ears, Nose, Throat (allergies, sinus)
____Cardiovascular (heart disease, high blood pressure)
____Gastrointestinal (ulcers)
____Respiratory (asthma, lung disease)
____Endocrine (diabetes, thyroid disease)
____Neurological (migraines, seizures)
____Bones, Joints (arthritis)
____Genitourinary (kidney disease)
____Integumentary (skin disease)
____Constitutional (weight gain/loss, fever)
____Psychiatric (anxiety, depression)
____Lymphatic/Hematologic (blood disease)
____Allergic (seasonal allergies)
____Cancer (type____________________________________)

Please list all medications that you take:____

Please list any medication you are allergic to:____

Social History:
Do You: Drink Alcohol? Yes____No____ Use Tobacco? Yes____No____ Use Illegal Drugs? Yes____No____

(please turn over and complete the other side)

Family Eye and Health History

Have any members of your family, living or deceased (parents, grandparents, siblings, children), been diagnosed with any of the following:

Disease/Condition	**Relationship to You**
____Glaucoma	______________________________
____Macular Degeneration	______________________________
____Cataracts	______________________________
____Retinal Detachment	______________________________
____Crossed Eyes	______________________________
____Blindness	______________________________
____Diabetes	______________________________
____High Blood Pressure	______________________________
____Arthritis	______________________________
____Cancer	______________________________
____Kidney Disease	______________________________

The Following Information Will Help Us Better Understand Your Vision Needs

What is your current occupation?____

What hobbies, sports, and recreational activities do you enjoy?________________________________

Do you wear prescription sunglasses?_____Yes_____No Are they polarized?_____Yes_____No

Are you interested in lenses that darken in sunlight?_____Yes_____No

Are you interested in thinner and lighter lenses than standard plastic?_____Yes_____No

Are you bothered by glare or reflections when driving at night?_____Yes_____No

Are you interested in coatings that minimize reflections off your lenses allowing more light into your eyes and making them more cosmetically appealing?_____Yes_____No

Are you interested in superior scratch-resistant coatings?_____Yes_____No

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If you wear contact lenses or are interested in wearing them, please carefully read the following and initial:

As a contact lens wearer, additional tests are provided for you. These tests are done to make sure your eyes are healthy, that the lenses fit your eyes properly, and to ensure that you are seeing as clearly as possible. Contact lens professional fees, more commonly known as contact lens fittings or evaluations, are for the extra testing and time taken by the Dr. and staff each year to properly evaluate your contact lenses. Contact lenses are prescribed medical devices that require a yearly evaluation and written prescription in order for you to “refill” your contact lenses. Most insurance plans cover a routine eye exam which determines your eye glass prescription and evaluates your eye health. Contact lens services are separate procedures that are often not covered by insurance, but that depends on your plan’s coverage. The cost for contact lens professional fees depends on the complexity of the lenses your prescription requires. Please ask any questions regarding this before receiving contact lens services.

_____ [Please initial here] I have read the above paragraph about your contact lens professional fees. I understand that I will be charged an additional fee for my contact lens exam based on the complexity of the lenses my prescription requires.

Please Carefully Read and Sign the Following

I acknowledge that professional fees are non-refundable for services rendered and are due at the time of service. I assume full responsibility for these fees and agree to pay them when due. I also authorize this office to bill my insurance (if applicable), and assign all payment directly to them, and authorize them to release any medical information necessary to process my claim. Should any insurance carrier deny payment for any reason whatsoever, I agree to promptly remit the unpaid fee. If payment is not promptly received and my account is referred to a collection agency, I agree to pay all costs, including reasonable attorney’s fees, and interest at the rate of 18% per annum.

Patient/Guardian____ Date_____/_____/_____