



Established Patient Registration Form

This form is for patients who have previously seen a doctor at NSVC.

North Suburban Vision Consultants, Ltd.

S. Barry Eiden, OD, FAAO
Shana Brafman, OD

Carol Barron, OD, FAAO
Stuart Sondheimer, MD, SC

Darin Strako, OD, FAAO
Alphonse Serpico, OD (Ret.)

Mr. Mrs. Ms. Dr.

Last Name

First Name

Middle Initial

Date of Birth

If you have had a change in your information since your last visit to our office, please indicate the new information below.

Address

City

State

Zip Code

Home Phone

Cell Phone

E-Mail

Employer

Occupation

Work Address

City

State

Zip Code

Work Phone

Spouse's Name

Family Physician Name

Phone

Driver's License Expiration Date

Hobbies and Recreational Interests

Insurance Information *Indicate changes since last visit.*

Primary Health Insurance Company

Policy #

Group #

Phone

Subscriber of insurance (if different than the patient)

Subscriber's Date of Birth

Relationship to Patient

Secondary Health Insurance Company (if applicable)

Policy#

Group #

Phone

Subscriber of insurance (if different than the patient)

Subscriber's Date of Birth

Relationship to Patient

Vision Insurance Plan (if applicable)

Member #	Group #	Phone
----------	---------	-------

Subscriber of insurance (if different than the patient)

Subscriber's Date of Birth	Relationship to Patient
----------------------------	-------------------------

Eye and Medical Information

Primary reason for visit to NSVC:

Have any blood relatives had a change in their eye health history since your last exam?
If Yes, please describe relation and disease. (Glaucoma, Macular Degeneration, Retinal Diseases, Optic Nerve Diseases)

Please describe any other eye/vision symptoms you may be experiencing beyond your primary reason for your visit.

If you have been examined at a different clinic or by a different eye doctor between now and your last visit to NSVC, please provide the following information:

Date of last eye examination	Doctor or Clinic
------------------------------	------------------

Do you currently wear glasses?

Use of glasses	Age of Glasses
----------------	----------------

Are you satisfied with your glasses?

If you have started wearing contact lenses prescribed by a different clinic or eye doctor, please fill out the following:

Are you satisfied with your contact lenses?

Type of current contact lenses (soft daily wear, soft extended wear, disposable daily wear, disposable extended wear, rigid gas permeable daily wear, rigid gas permeable extended wear, CRT/Ortho-K gas permeable)

If disposable, what is the frequency of replacement (daily, weekly, 2-week, 1-month, 3-month, 6-month, other)

Age of current contact lenses

Name (Brand) of contact lens care system currently used

If you know, please indicate current contact lens parameters:

Right:	brand	base curve	diameter	power
--------	-------	------------	----------	-------

Left:	brand	base curve	diameter	power
-------	-------	------------	----------	-------

Additional Medical History (Review of Systems)

Indicate any changes to your general medical health history since your last examination at NSVC.

When was your last physical or general medical evaluation?

List any changes in medical conditions that you are being treated or monitored for:

List any changes to medications you are taking and for what reason:

List any changes in allergies that you have (medications, environmental, etc.):

Do you smoke? (If Yes, how much?)

Do you consume alcohol? (If Yes, how much?)

General

Check all that apply if you experience a problem:

Fever

Weight Loss

Ear, Nose or Throat

Sinusitis

Nasal Allergies

Hearing loss

Dry Mouth

Heart Circulation

Slow or Irregular heartbeat

Heart problem

Ankle swelling

Kidney problems

Blood/Lymph Nodes

Bruising or bleeding

Lungs/Breathing

Asthma

Bronchitis

Skin

Eczema

Psoriasis

Dry skin

Skin Lesions

Digestive System

Ulcer

Hernia

Nausea/vomiting

Other

Arthritis

Thyroid

Diabetes

Hypertension

Pregnant

Cancer

Payment Information

I understand that my insurance coverage may not cover all expenses incurred at North Suburban Vision Consultants, Ltd. I personally accept responsibility of all charges incurred which are not covered by my insurance.

Payment is expected when services and orders are placed unless we are participating preferred providers in your medical and/or vision plan. Any fees for services or materials not covered or above your insurance coverage must be paid at time of service and material order.

I understand that if my account at North Suburban Vision Consultants becomes delinquent and such debt is given to a collection service or attorney for collection, I will be responsible for any and all extra charges, all inclusive.

Person responsible for this account:

By signing here, I agree to all terms indicated above.

Signature: ***your signature needed at time of appointment***

Date:

Print Name:

© North Suburban Vision Consultants. All Rights Reserved.

© Design by: [asdf Software Company](#).