North Suburban Vision Consultants Ltd.
Ours is a 20/20 Commitment!
Deerfield 847-412-0311
administration@nsvc.com

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
Carol Barron, OD, FAAO
Kathleen Albrecht, MD
Kelly Cohen, OD
Megan Allen, OD, FAAO
Milana Matz, OD
Rebecca Sarran, MD
Sarah Rogers, OD
Vanee Virasch, MD

(•) 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 examinatio n 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: