



## Established Patient Registration Form

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

North Suburban Vision Consultants, Ltd.

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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)***

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Member #	Group #	Phone
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Subscriber of insurance (if different than the patient)

Subscriber's Date of Birth	Relationship to Patient
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**Eye and Medical Information**

Primary reason for visit to NSVC:

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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)

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

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*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:*

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Date of last eye examination	Doctor or Clinic
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Do you currently wear glasses?

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Use of glasses	Age of Glasses
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Are you satisfied with your glasses?

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

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Are you satisfied with your contact lenses?

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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)

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

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Age of current contact lenses

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Name (Brand) of contact lens care system currently used

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If you know, please indicate current contact lens parameters:

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Right:	brand	base curve	diameter	power
Left:	brand	base curve	diameter	power

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**Additional Medical History (Review of Systems)**

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

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When was your last physical or general medical evaluation?

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

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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:

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

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

Date:

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Print Name:

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