



New Patient Registration Form

This form is for patients who are new to NSVC. [Established patients click here.](#)

North Suburban Vision Consultants, Ltd.

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Mr. Mrs. Ms. Dr.

Last Name

First Name

Middle Initial

Date of Birth

Social Security #

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

Referred by:

Insurance Information

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:

 routine comprehensive eye health and vision exam

 specific eye or vision problems (*Please list*)

Date of last eye examination

Doctor or Clinic

Do you currently wear glasses?

Use of glasses (distance, near, both)

Age of Glasses

Are you satisfied with your glasses? YES NO

Are you interested in Refractive Eye Surgery (LASIK, etc.)/ Cataract Surgery?:

Are you interested in Oculoplastic (eyelid) Surgery or Aesthetic Injections (eg Botox, etc.):

Are you interested in Corneal Reshaping Treatment (CRT)? YES NO

Have you ever had any medical problems with your eyes (infections, injuries, diagnosed eye diseases, or eye surgery)?

If Yes, please describe:

Have you ever had an eye turn (strabismus) or lazy eye (amblyopia)?

Have you ever been diagnosed with lazy eye (amblyopia)?

Have you ever had vision therapy (eye exercises)?

Are you interested in Vision Therapy?

If Yes, please describe:

Do you have any blood relatives with a history of eye disease (Glaucoma, Macular Degeneration, Retinal Diseases, Optic Nerve Diseases)? YES NO

If Yes, describe relation and disease:

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

Contact Lens Wearers

Do you currently wear contact lenses? YES NO
(If No, are you interested in contact lenses? YES NO)

Are you satisfied with your contact lenses? YES NO

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)

When was your last physical or general medical evaluation?

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

List any medications you are taking and for what reason:

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

Do you smoke? YES NO (If Yes, how much?)

Do you consume alcohol? YES NO (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:

Date:

Print Name:
