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

New Patient Registration Form

This form is for patients who are new to NSVC. Established patients click here.

North Suburban Vision Consultants, Ltd.
S. Barry Eiden, OD, FAAO Carol Barron, OD, FAAO Milana Matz, OD
Vesna Simic, OD Kathleen Albrecht,MD Vanee Virasch, MD Nina Goyal, MD

○ 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? YES NO

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: