Kenneth A. Lebow,
O.D., F.A.A.O.
& Associates

PATIENT REGISTRATION FORM

Today's Date: ______________

Patient Name: Mr. Mrs. Ms. Dr. ______________________________

Date of Birth: ______________ **SSN:** ______________ ☐ Male ☐ Female

Address: ______________________________

Home Number: ______________ **Cell Phone:** ______________

Email Address: ______________ **Marital Status:** ______________

Race: ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Language: ☐ English ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Other: ______________

VA Resident: ☐ Full Time ☐ Part Time If Part Time, please complete information below.

From: __________ To: __________ Secondary Home Phone: ______________

Secondary Address: ______________________________

Other Eye Care Physician: ______________ Phone: ______________ Fax: ______________

Responsible Party Information (If different from above):

Name: ______________________________ Date of Birth: ______________

Primary Insurance: ______________________________ **Policy #:** ______________

Secondary Insurance: ______________________________ **Policy #:** ______________

Are you or your spouse employed full time or part time? ☐ Yes ☐ No

If so, do you have health insurance through your employer? ☐ Yes ☐ No

Are you enrolled in an HMO? ☐ Yes ☐ No

Do you need authorization from your Primary Physician to see a specialist? ☐ Yes ☐ No

Have you been in a skilled nursing a facility and/or hospice care in the past 6 months? ☐ Yes ☐ No

If yes, what is the name of the Facility? ______________________________

How did you hear about Dr. Lebow / Griffey Eye Care? ☐ Billboard/Building Signage ☐ Doctor ☐ Event

☐ Family/Friend ☐ Google/Online Search ☐ Other: ______________

Emergency Contact: ______________________________

Relationship: ______________________________ Phone: ______________

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Patient Name: ____________	Date of Birth: ________	Today's Date: ____________

Primary Care Physician: ______________________ Phone: ______________

Address: ______________________________ Fax: ______________

Primary Eye Physician: ______________________ Phone: ______________

Address: ______________________________ Fax: ______________

Height: ______________________ **Weight:** ______________________

Ocular History:

- ☐ Yes ☐ No Cataracts
- ☐ Yes ☐ No Cornea Transplant
- ☐ Yes ☐ No Diabetic Retinopathy
- ☐ Yes ☐ No Dry Eye Syndrome
- ☐ Yes ☐ No Glaucoma
- ☐ Yes ☐ No LASIK / Epi-LASEK
- ☐ Yes ☐ No Macular Degeneration
- ☐ Yes ☐ No Punctal Plugs
- ☐ Yes ☐ No Retinal Detachment
- ☐ Yes ☐ No YAG Laser
- ☐ Other: ______________________________

What is the reason for your visit today?

- ☐ Blurred Vision RT LT
- ☐ Decreased Vision RT LT
- ☐ Discharge RT LT
- ☐ Double Vision RT LT
- ☐ Dry Eyes RT LT
- ☐ Flashes RT LT
- ☐ Floaters RT LT
- ☐ Headache RT LT
- ☐ Itching RT LT
- ☐ Pain RT LT
- ☐ Red Eye RT LT
- ☐ Tearing RT LT
- ☐ Other: ______________________________

Immunization / Vaccination:

- ☐ Yes ☐ No Influenza Date/s: ______________________
- ☐ Yes ☐ No Pneumococcal Date: ______________________

Surgical History:

- ☐ Yes ☐ No Appendectomy
- ☐ Yes ☐ No Carotid Endarterectomy
- ☐ Yes ☐ No Gallbladder
- ☐ Yes ☐ No Heart Bypass
- ☐ Yes ☐ No Hernia
- ☐ Yes ☐ No Hemorrhoidectomy
- ☐ Yes ☐ No Hysterectomy
- ☐ Yes ☐ No Mastectomy
- ☐ Yes ☐ No Prostate
- ☐ Yes ☐ No Skin Cancer Removal
- ☐ Other: ______________________________

Allergies:

- ☐ Yes ☐ No Latex Please describe: ______________________
- ☐ Yes ☐ No Anesthesia Please describe: ______________________

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Patient Name: ____________	Date of Birth: ________	Today's Date: ____________

Family History:

☐ Yes ☐ No Cataracts ☐ Mother ☐ Father ☐ Other: ______________

☐ Yes ☐ No Diabetes ☐ Mother ☐ Father ☐ Other: ______________

☐ Yes ☐ No Glaucoma ☐ Mother ☐ Father ☐ Other: ______________

☐ Yes ☐ No Macular Degeneration ☐ Mother ☐ Father ☐ Other: ______________

☐ Yes ☐ No Retinal Detachment ☐ Mother ☐ Father ☐ Other: ______________

☐ Other: ______________ ☐ Mother ☐ Father ☐ Other: ______________

Social History:

Occupation: ______________________ ☐ Retired ☐ Disabled ☐ Not Working

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Walking ☐ Other: ______________

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

Past / Present Medical History:

☐ Yes ☐ No Abdominal Pain

☐ Yes ☐ No Alzheimer's

☐ Yes ☐ No Anxiety

☐ Yes ☐ No Arthritis

☐ Yes ☐ No Asthma

☐ Yes ☐ No Autoimmune Disease

☐ Yes ☐ No Bleeding

☐ Yes ☐ No Bruises

☐ Yes ☐ No Cancer

☐ Yes ☐ No Cardiovascular Disease

☐ Yes ☐ No Cholesterol

☐ Yes ☐ No COPD

☐ Yes ☐ No Dementia

☐ Yes ☐ No Depression

☐ Yes ☐ No Diabetes: Type 1 or Type 2

☐ Yes ☐ No Headaches

☐ Yes ☐ No Hearing Aides

☐ Yes ☐ No Hearing Loss

☐ Yes ☐ No Heart Attack: Year ________

☐ Yes ☐ No High Blood Pressure/Hypertension

☐ Yes ☐ No Irregular Heartbeat

☐ Yes ☐ No Kidney Disease

☐ Yes ☐ No Kidney Failure

☐ Yes ☐ No Kidney Stones

☐ Yes ☐ No Migraine

☐ Yes ☐ No Nausea

☐ Yes ☐ No Parkinson

☐ Yes ☐ No Psoriasis

☐ Yes ☐ No Seasonal Allergies

☐ Yes ☐ No Sinus Problems

☐ Yes ☐ No Skin Rashes

☐ Yes ☐ No Stroke: Year ________

☐ Yes ☐ No Stomach Ulcers

☐ Yes ☐ No Thyroid Disease

☐ Other: ______________________________________