Alachua Family Eye Care   New Patient Registration

Date__________________ **DOB**_________________

Patient's Name____ **Mr. Mrs. Ms. Miss Dr.**

Guardian/Guarantor (if applicable)____

Address____**City**___________________**State**_____ **Zip**_______

Phone______________________ **Work Phone**_____________________**E-Mail**_____________________________________

Who Referred You to Us? (Name) ____

Circle: Family Member Friend Website Social Media Insurance Listing Physician Walk- In

Occupation____

Name of Employer____**City**__________________________________

Special Visual Demands (work or hobbies)____

Please list household members that come to our office____

Please circle if you have (or ever had) any of the following: Diabetes High Blood Pressure Stroke

Thyroid dysfunction HIV Migraine Headache MS Lupus Rheumatoid Arthritis Cancer

Please circle if you have (or ever had) any of the following: Cataracts Lazy Eye Glaucoma Dry Eyes

Macular Degeneration Eye Infection Eye Allergies Eye Injury Eye surgery Retina Disease

Cornea Disease Vision Loss

Medications:____

____

Do you have any drug allergies? ____

Do you wear glasses? Y or N **Are you happy with your current glasses?** Y or N

New glasses today? Y or N or Unsure **Wear Contacts?** Y or N or Interested

Vision Insurance Y or N **Company**____

Medical Insurance Y or N **Company**____

Primary Care Physician____

I have read and understand the HIPPA privacy policy **Signature**____