

# HUGO OPTICAL REGISTRATION FORM

## PATIENT INFORMATION

Patient's first name:		Last name:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Home Phone: (    )	Work Phone: (    )	E-mail:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:				Apt#	
City:		State:	ZIP Code:		
Occupation:		Employer:			
Chose clinic because/Referred to by <i>(please check one box)</i> :		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend -	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Other		
Other family members seen here:					

## MEDICAL HISTORY

Date of last exam: / /	What is your reason for seeking eye care at this time?				
Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many hours per day do you wear your contacts?			
What type of Contacts do you wear? <i>(check all that apply)</i>	<input type="checkbox"/> Soft lenses		<input type="checkbox"/> Toric		<input type="checkbox"/> Disposable
	<input type="checkbox"/> Rigid gas permeable		<input type="checkbox"/> Daily wear (daytime only)		<input type="checkbox"/> Extended wear (sleep in)
How often do you change your contact lenses?					
Do you or your family members have any of the following? <i>If so, please list who:</i>					
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Thyroid problem	<input type="checkbox"/> Strabismus (eye turn)	
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Retina Disease	<input type="checkbox"/> Cataract	<input type="checkbox"/> Amblyopia (lazy eye)	<input type="checkbox"/> Macular Degeneration	
Have you ever experienced? <i>(check all that apply)</i>					
<input type="checkbox"/> Color vision problems		<input type="checkbox"/> Double vision		<input type="checkbox"/> Flashes of light	
<input type="checkbox"/> Night vision problems		<input type="checkbox"/> Eye infection		<input type="checkbox"/> Eye surgery	
<input type="checkbox"/> Frequent headaches					
How many hours do you work on computer per day?					
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			( Women only ) Are you pregnant or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**ARE YOU CURRENTLY TAKING ANY MEDICATION?** *(Please list)*

## DILATION INFORMATION

To provide the most complete evaluation of your eyes it is sometimes necessary to administer drops to dilate your pupils. Dr. Petronack will discuss how the dilation may temporarily affect your vision. *Please check one of the following:*

- I give my permission to have my eyes dilated  
  I am undecided and would like to discuss  
  I have read & understand the importance of dilation, but refuse procedure

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Insurance Provider:	Policy Number:
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hugo Optical or insurance company to release any information required to process my claims. We have a comprehensive "notice of privacy practices" that describes the use and disclosure of your personal medical information in detail as per federal law. I understand these policies are posted at the front desk and are available as individual copies for my use.

\_\_\_\_\_  
**Patient/Guardian signature**

\_\_\_\_\_  
**Date**