JANSEN OPTICAL

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

TODAY'S DATE:

Circle One Mr. Ms. Mrs. Dr.	First Name:	Middle Initial:	Last Name:	SSN: XXX- XX - _____ DOB: ___/___/_____ Age:_____

Street Address:	City/State:	Zip Code:

Primary Contact # (Cell, Home, Work)	Secondary Contact #.:(Cell, Home, Work)	Emergency Contact Name & Number.:
Occupation/Grade:	Employer/School	Email Address:

Whom may we thank for referring you to our office:

☐Annual Postcard ☐Insurance Plan ☐Yellow Pages ☐Google ☐Yelp ☐Doctor ☐Website

MEDICAL INFORMATION

Chief Complaint (Reason for today's visit):

Please check boxes if you experience any of the following:

Watery or itchy Eyes	☐Yes	☐ No	Floaters/Spots	☐Yes	☐ No	Blurry Vision Distance	☐Yes	☐ No
Dry Eyes	☐Yes	☐ No	Headaches	☐Yes	☐ No	Blurry Vision Near	☐Yes	☐ No
Flashes of Light	☐Yes	☐ No	Light Sensitivity	☐Yes	☐ No	Eye Pain/Strain	☐Yes	☐ No
Double Vision	☐Yes	☐ No	Night Blindness	☐Yes	☐ No	Pink or Red Eye	☐Yes	☐ No

Please List All Current Medications:

Females: Are you pregnant? ☐Yes ☐No

Please List All Allergies to Medications: **Do you smoke?** ☐Yes ☐No

Please List Eye Medications: **Height:____ft____inches Weight:_____lbs**

Name & Phone # of Family Doctor:

Check applicable symptoms or diagnoses:			Check if you have difficulties with any of the following:	
Diabetes If Self, Year Diagnosed:_____ ☐Type I ☐Type II	☐Self	☐ Family	Digestive System	☐Yes ☐No
Lasik Surgery Date of Surgery:_____	☐Yes	☐No	Ears/Nose/Throat	☐Yes ☐No
Eye Injuries/Surgery	☐Yes	☐No	Cardiovascular	☐Yes ☐No
Arthritis	☐Yes	☐No	Respiratory	☐Yes ☐No
High Blood Pressure	☐Yes	☐No	Musculoskeletal	☐Yes ☐No
Heart Disease	☐Yes	☐No	Skin Disorders	☐Yes ☐No
Seasonal Allergies	☐Yes	☐No	Thyroid	☐Yes ☐No
Family Eye History			Neurological	☐Yes ☐No
Glaucoma	☐Self	☐ Family	Lymphatic	☐Yes ☐No
Retinal Defects/Macular Degeneration	☐Self	☐ Family	Immunological	☐Yes ☐No
Cataracts	☐Self	☐ Family	Nervous	☐Yes ☐No
Strabismus/Amblyopia/Lazy Eye	☐Self	☐ Family	Other:	☐Yes ☐No

Please sign below to indicate that all the information above is correct:

Patient/Guardian Signature: X_____ **Date:** _____/_____/_____ Revised 10/12/2015

For Office Use only:

Dr.'s Signature:_____ Technician's Initials:_____