Dr. Daniel Walker
Family Vision Care

Patient Registration

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Nick name: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ Marital Status: _____

Home Phone: _____ Mobile: _____ Work: _____

Email: _____ Employer/ Occupation: _____

Primary Insurance Information

Insurance Name: _____ ID #_____ Group #: _____

Subscribers Name: _____ Birthdate: _____

Relationship to patient: _____

Secondary Insurance Information

Insurance Name: _____ ID#_____ Group#_____

Subscribers Name: _____ Birthdate: _____

Relationship to patient: _____

Eye Health History

Physician's Name: _____ Date of last eye exam: _____

Do you wear Glasses? _____ Frequency: All the time___ Occasionally___ Reading___ Driving___

Do you wear Contacts? _____ Type: _____ Hours/Days_____

Place a check mark to indicate you have had any of the following:

Bloodshot eyes ____ Blurred Vision (distance)____ Blurred Vision (near)____ Burning eyes____ Cataracts____

Color vision (poor)____ Crossed eyes____ Discharge from eyes____ Dizzy spells____ Double vision____

Dry eyes____ Eye infection____ Eye injury____ Eye strain____ Fainting/Blackouts____ Floaters/spots____

Glaucoma____ Headaches____ Itching eyes____ Light sensitive____ Loss of vision____ Night vision (poor)____

Red eyes____ Seeing spots____ Seeing flashes____ Twitching eyelid____ Vision (poor)____ Watering eyes____

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Health History

Primary Physician: _____ Phone#_____

Date of last exam: _____

Place a check mark to indicate you have had any of the following:

AIDS/HIV____ Arthritis____ Artificial heart valve____ Artificial joints____ Asthma____ Bleeding____

Blindness____ Cancer____ Cataracts____ Chemical Dependency____ Diabetes____ Drug sensitivity____

Emphysema____ Epilepsy____ Eye surgery____ Glaucoma____ Hay fever____ Heart condition____

Hepatitis____ (Type_____) High blood pressure____ Kidney disease____ Lazy eye____ Lupus____

Headaches____ Pacemaker____ Poor color vision____ Retinal disease____ Rheumatic Fever____ Shingles____

Skin condition____ Stroke____ Thyroid condition____ Tuberculosis____ Turned eye____

Are you pregnant? _____ Number of children: _____

Tobacco Use? _____ Frequency: _____ Alcohol Use? _____ Frequency: _____

Place check mark to indicate if a family member has had any of the following:

AIDS/HIV____ Arthritis____ Artificial heart valve____ Artificial joints____ Asthma____ Bleeding____

Blindness____ Cancer____ Cataracts____ Chemical Dependency____ Diabetes____ Drug sensitivity____

Emphysema____ Epilepsy____ Eye surgery____ Glaucoma____ Hay fever____ Heart condition____

Hepatitis____ (Type_____) High blood pressure____ Kidney disease____ Lazy eye____ Lupus____

Headaches____ Pacemaker____ Poor color vision____ Retinal disease____ Rheumatic Fever____ Shingles____

Skin condition____ Stroke____ Thyroid condition____ Tuberculosis____ Turned eye____

Medications

List any medications you are currently taking, including eye drops:

_____
_____
_____
_____

Allergies

List any allergies to medications or other substances:

_____
_____
_____
_____

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I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Daniel Walker all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions.

I consent to the release and re-disclosure of my financial records to enable or facilitate the collection, verification or settlement of my account for any amounts due for me or any third-party payer, health maintenance organization, insurer or other health benefit plan. This consent applies to Dr. Daniel Walker. Any of it affiliates or agents, lenders, or any third-party services acting on behalf of Dr. Daniel Walker or any of his affiliate.

I, _____ (print full name) certify that I and/or my dependent(s), have insurance coverage and assign directly to Dr. Daniel Walker all insurance benefits.

_____ _____

Signature of patient/ responsible party Date

_____

Relationship to patient