Drs. Sherman, Taylor & Bisotti

Keith T. Sherman, O.D. — Gregory E. Taylor, O.D. — Anthony J. Bisotti, O.D.

HIGHSCHOOL PATIENT REGISTRATION

NAME_____

HEAD OF HOUSEHOLD_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

DATE OF BIRTH_____/_____/_____ AGE_____

SCHOOL YOU ATTEND_____

TELEPHONE NUMBER: _____

PARENTS WORK NUMBER: _____

OFFICE POLICIES

Fees will be charged in relation to services rendered. We accept payment from several insurance companies for routine vision services and most insurance companies for medical eye problems. A deposit of approximately 50% is required before eye wear will be ordered, with the balance due at the time of dispensing. Special terms will be made for contact lenses and other terms shoud be discussed prior to orders.

Sign here_____

CIRCLE THE METHOD(s) OF PAYMENT YOU WILL BE USING

CASH CHECK INSURANCE MEDICARE LION'S CLUB

VISA/MASTERCARD/DISCOVER KENTUCKY MEDICAL CARD

Please finish the other side and return it to the receptionist.

Revised 5/6/2011

GENERAL PATIENT HISTORY FORM for new patients

Approximately how long has it been since an eye doctor last examined your eyes?_____ Today's date ____/____/____

Do you presently wear glasses? Y N Contact Lenses? Y N Safety Glasses, when needed? Y N

Circle all of the following eye conditions you now have or have had.

Decreased Far Vision	Itching Eyes	Lazy Eyes	Floaters
Decreased Near Vision	Mattering of Eyes	Crossed Eyes	Flashing Lights
Decreased Side Vision	Redness of Eyes	Out Turning Eyes	Halos Around Lights
Decreased Color Vision	Eye Injury	Glaucoma	Sensitivity to Light
Poor Depth Perception	Eye Surgery	Retinal Disease	Glare
Double Vision	Eyes That Bulge	Macular Degeneration	Other _____

List any hospitalizations, operations, major injuries and illnesses:_____

_____

Circle all of the following conditions that run in your family.

Cataracts	Glaucoma	Macular Degeneration	Color Vision Deficiencies
Blindness	Diabetes	Cancer	Lazy Eye

If you smoke cigarettes, how many packs a day? _____ If you drink alcohol, how many drinks per week? _____

Who is your family medical Doctor? _____ How long has it been since he/she last examined you? _____

List all pills, tablets, or other medication you take. _____

_____

_____

List all allergies that you have to medications. _____

Circle all of the following conditions you now have or have had.

Heart Disease	Cancer	Ears, Nose, or Throat Problems	Persistent Fever
High Blood Pressure	Allergies	Blood (Hepatitis, Anemia) Disease	Kidney Disease
Slow Pulse Rate	Chest Pains	A Cold in the past 2 Weeks	Skin Problems
Bleeding Problems	Asthma	Excessive Dryness of Mouth	Thyroid Disorder
Persistent Cough	Ulcer	Rheumatic Fever	Stomach Problems
Arthritis	Stroke	Lung (Emphysema, Tb) Problems	Neurologic Disease
Headaches	Head Injury	Reproductive System Problem	Psychiatric Problems
Shortness of Breath	Diabetes	Unexplained Weight Loss	Other _____

What hobbies, sports, or recreational activities do you enjoy? _____

List any other information that you feel we should know about. _____