Regina Coleman Compton, OD, PSC

Family Eye Care Professionals Date:_____

Name (Last)_____(First)_____ Preferred_____

Mailing Address_____City_____St_____Zip Code_____

Date of Birth_____ Social Security No._____ SEX: Male or Female

Email Address:_____ Marital Status_____

Employer:_____ Occupation:_____

Home Phone (__)_____ Daytime Phone (__)_____ Cell phone (__)_____

Communication Preferred: Email Telephone Postal May we text you: Yes or No

Referred by_____ Yellow Pages Family Insurance TV Other

Race:	Native American/Native Alaskan	☐	Ethnicity:	Hispanic/Latino	☐
	Asian	☐		Native Hawaiian/Other Pacific Island	☐
	Black/African American	☐		Not Hispanic/Latino	☐
	Hispanic	☐			
	Native Hawaiian/Other Pacific Island	☐			
	White	☐			

SPECIAL PERMISSION-PLEASE CHOOSE YOUR RESPONSE AND INITIAL AND DATE THE STATEMENTS BELOW:

1. I give my permission for photos of me to be used for marketing purposes. Photos may be on display in office, on Facebook, and on Family Eyecare Professionals, LLC's web site. I understand that no health information will be attached to pictures, only first names of our happy patients.

_____ Yes _____NO Initial_____ Date_____

2. I give permission to leave voice mail or answering machine messages at the number I listed previously as my home number or cell phone number. The message can include the nature of the call but NOT specific information

_____Yes _____NO Initial_____ Date_____

3. I give my permission to discuss medical treatment and billing information with person(s) listed below. If no names are listed below NO INFORMATION will be given out to anyone but the patient or legal guardian without signed written permission. We are sorry for any inconvenience this may cause.

Name_____Relationship_____Name_____Relationship_____
Name_____Relationship_____Name_____Relationship_____

Initial_____ Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name_____ Date_____

Patient Signature/Pt Representative(if patient is minor or unable to sign)_____

Relationship of Patient Representative to Patient _____

Patient Name:_____ DOB:_____

Primary Care Physician:_____ Date Last Seen_____

Medical/Family History (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins, and herbal therapy)

_____

_____

List all major surgeries (Eye surgery included)

_____

_____

List any allergic reactions to medications or eye drops _____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

Disease/Condition	Yourself Yes	No
Cataract.	*	*
Eye Turn	*	*
Glaucoma	*	*
Macular Degeneration	*	*
Retinal Detacment	*	*

	Yes	No
Are you pregnant?	*	*
Are you breast feeding?	*	*

	Family Member Yes	No	Relationship (Blood Relatives Only)
Blindess	*	*	_____
Eye Turn	*	*	_____
Glaucoma	*	*	_____
Macular Degeneration	*	*	_____
Retinal Detachment	*	*	_____

Other:

_____

Review of System: Please circle below if you have or ever had problems with following conditions:

Allergic/Immunoloic	Ear,Nose and Throat	Gastrointestinal	Skin/integumentary	Psychiatric
*None	*None	*None	*None	*None
*Lupus	*Sinusitis	*Chrohns	*Eczema	*Depression
*Rhematoid Arthritis	*Upper Respiratory	*Colitis	*Rosacea	*Bi Polar
*Environmental Alleriges	Tract Infection	*Acid Reflux	*Psoriasis	*Schizophrenia
*Seasonal Allergies	*Other	*Ulcer	*Other	*Other
*Other		*Other		

Cardiovascular	Endorcrine/Glands	Respiratory	Muscle/Skeletal	Genital/Urinary
*None	*None	*None	*None	*None
*High Blood Pressure	*Diabetes	*Asthma	*Arthritis	*Urniary Tract
*Heart Disease	*Hormone Dysfunction	*Bronchitis	*Fibromyalga	Infection
*Stroke	*Thyroid Dysfunction	*Emphysema	*Ankylosing Spondylitis	*HIV positive
*Vascular Disease	*Other	*Other	*Other	*Herpes
*High Cholesterol				*Other

Hematologic/Lymphatic	Neurological	General Health	Social
*None	*None	*None	*Tobacco Use:
*Anemia	*Multiple Sclerosis	*Weight loss/gain	Current Smoker Former Smoker
*Leukemia	*Epilepsy	*Fever	*Non Prescription Drugs_____
*Bleeding Disorder	*Tremors	*Fatigue	*Alcohol Consumption_____
*Other	*Other	*Trauma	*Weight_____ Height_____

Please sign below to acknowledge this form is current and correct:

Signature:_____ Date:_____ Reviewed by Doctor Initals:_____