FAMILY EYE CARE
PROFESSIONALS

Regina Coleman Compton, O.D.

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
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic
- ☐ Native Hawaiian / Other Pacific Island
- ☐ White

Ethnicity:
- ☐ Hispanic / Latino
- ☐ Native Hawaiian / Other Pacific Island
- ☐ Not Hispanic / Latino

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 Eye Care Professionals, LLC's website. I understand that no health information will be attached to the 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 mat 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 Detachment	*	*

	Yes	No
Are you pregnant?		
Are you breast feeding?		

	FAMILY MEMBER	
	Yes	No
Blindness	*	*
Eye Turn	*	*
Glaucoma	*	*
Macular Degeneration	*	*
Retinal Detachment	*	*

Relationship (blood relatives only)

. . . . . .

. . . . . .

. . . . . .

. . . . . .

Other

. . . . . .

REVIEW OF SYSTEM: Please circle below if you have or ever had problems with following conditions:

Allergic / Immunologic
*None
*Lupus
*Rhematoid Arthritis
*Environmental Allergies
*Seasonal Allergies
*Other

Ear, Nose and Throat
*None
*Sinusitis
*Upper Respiratory Tract Infection
*Other

Gastrointestinal
*None
*Chrohns
*Colitis
*Acid Reflux
*Ulcer
*Other

Skin / Integumentary
*None
*Eczema
*Rosacea
*Psoriasis
*Other

Psychiatric
*None
*Depression
*Bi Polar
*Schizophrenia
*Other

Cardiovascular
*None
*High Blood Pressure
*Heart Disease
*Stroke
*Vascular Disease
*High Cholesterol

Endocrine / Glands
*None
*Diabetes
*Hormone Dysfunction
*Thyroid Dysfunction
*Other

Respiratory
*None
*Asthma
*Bronchitis
*Emphysema
*Other

Muscle / Skeletal
*None
*Arthritis
*Fibromyalga
*Ankylosing Spondylitis
*Other

Genital / Urinary
*None
*Urinary Tract Infection
*HIV Positive
*Herpes
*Other

Hematologic / Lymphatic
*None
*Anemia
*Leukemia
*Bleeding Disorder
*Other

Neurological
*None
*Multiple Sclerosis
*Epilepsy
*Tremors
*Other

General Health
*None
*Weight loss/gain
*Fever
*Fatigue
*Trauma

Social
*Tobacco Use:
Current Smoker Former Smoker
*Non Prescription Drugs . . . . . .
*Alcohol Consumption . . . . . .
*Weight . . . . . Height . . . . . .

Please sign below to acknowledge this form is current and correct

Signature . . . . . Date . . . . . Reviewed by Doctor Initials: . . . . . .