



AVON VISION ASSOCIATES



Dr. Daniel T. Fitzpatrick Dr. Sally Austin-Fitzpatrick
REGISTRATION HISTORY

DATE _____

PATIENTS NAME _____ DATE OF BIRTH _____

EMERGENCY CONTACT PERSON _____ PH _____

SPOUSE OR GUARDIAN _____ DATE OF BIRTH _____

STREET ADDRESS _____ E-MAIL _____

CITY/STATE/ZIP _____

HOME PH _____ WORK PH _____ CELL PH _____

OCCUPATION _____ EMPLOYER _____

PRIMARY CARE PHYSICIAN _____ PH _____

PHARMACY _____ PH _____

ARE YOU TAKING ANY MEDICATIONS?(Please List) _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____

DATE OF LAST EYE EXAM _____ DATE OF LAST PHYSICAL _____

PRIMARY REASON FOR TODAYS VISIT _____

COMPREHENSIVE VISUAL EXAMINATIONS DO NOT INCLUDE CONTACT LENS FITTING OR EVALUATION. SEPARATE FEES APPLY TO THESE SERVICES.

ARE YOU INTERESTED IN CONTACT LENSES? _____

ARE YOU WEARING CONTACT LENSES? _____ TYPE(soft or rigid) _____

TYPE OF DISINFECTION (heat or chemical) _____

ARE YOU INTERESTED IN LASER VISION CORRECTION?

WHOM MAY WE THANK FOR REFERRING YOU?

Assignment of Benefits: I, the undersigned, certify that I (or my dependent) have coverage with my insurance as presented and assign directly to Daniel T. Fitzpatrick, O.D. all insurance benefits, payable to me for services rendered. I understand that I am responsible for payment of deductibles, co-payments, and/or non-covered services. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize RELEASE OF MEDICAL INFORMATION to my insurance carrier, or requested physician to provide continuity of care. I authorize the use of this signature on all insurance submissions. I understand that it is my responsibility to inform the doctor's office if there is a change in my insurance information.

THIS INFORMATION IS CONFIDENTIAL AND WAS GIVEN BY (signature) _____

-OVER-



HAVE YOU OR ANY FAMILY MEMBER EVER HAD: S=SELF F=FAMILY

- | | |
|--|--|
| <input type="checkbox"/> ARE YOU PREGNANT/NURSING | <input type="checkbox"/> SUDDEN LOSS OF VISION |
| <input type="checkbox"/> VISION TRAINING/EYE EXERCISES | <input type="checkbox"/> EYE/HEAD INJURY |
| <input type="checkbox"/> ASTHMA/BRONCHITIS/LUNG DISORDER | <input type="checkbox"/> THYROID TROUBLE |
| <input type="checkbox"/> USE TOBACCO PRODUCTS | <input type="checkbox"/> CANCER/TUMORS |
| <input type="checkbox"/> DRUG OR ALCOHOL ADDICTON | <input type="checkbox"/> FAINTING/DIZZINESS |
| <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> CATARACTS |
| <input type="checkbox"/> COLOR BLINDNESS | <input type="checkbox"/> BLINDNESS |
| <input type="checkbox"/> RETINAL DISEASE | <input type="checkbox"/> EYE SURGERY |
| <input type="checkbox"/> EYE TURN/LAZY EYE | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> HEART/VASCULAR DISORDER | <input type="checkbox"/> RASHES |
| <input type="checkbox"/> KIDNEY/LIVER DISORDER | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> HIGH/LOW BLOOD SUGAR | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> FLASHES, FLOATERS, OR SPOTS | |

SPORTS & HOBBIES

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> GOLF | <input type="checkbox"/> TENNIS |
| <input type="checkbox"/> HUNTING | <input type="checkbox"/> READING |
| <input type="checkbox"/> FISHING | <input type="checkbox"/> SEWING/KNITTING |
| <input type="checkbox"/> BOATING | <input type="checkbox"/> GARDENING |
| <input type="checkbox"/> SKIING | <input type="checkbox"/> WOODWORKING |
| <input type="checkbox"/> SWIMMING | <input type="checkbox"/> PAINTING |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> OTHER: _____ |
| _____ | _____ |