Patient Registration Form

Shelby R. Wilkes, M.D.

Vitreoretinal Surgery

Diabetic Retinopathy

ERG, EOG, and VER Surgery

Jettie M. Burnett, M.D.

Cataract Surgery

Corneal Surgery Laser

Surgery

Glaucoma Care

Martin F. Wilkes, M.D.

Vitreoretinal Surgery

Diabetic Retinopathy

Ocular Trauma

PATIENT REGISTRATION FORM

Date: _____

Patient Name: _____ Social Security Number: _____ -_____ - ____

Date of Birth: ____/___/_____ Sex: M / F (Circle One) Married /Single/Divorced/Single

Address: _____ City: _____State: _____ Zip: _____

Home Phone :(___) _____ - _____ E-mail Address: _____

Employer Name: _____Employer Phone Number :(_____)_____ - ____

Employer Address:_____ City: _____ State:_____Zip: _____

Primary Care Physician_____ Phone: (____) _____-_____

Pharmacy:_____ Phone(____)_____-____ Address: _____

Guarantor Information

Name:_____Social Security Number ____ -_____ - ____

Date of Birth ____/____/_____Address: _____

Emergency Contact

Name: _____Phone :(_____) __ - _____ Cellular (____) ____

Address: ____

Primary Insurance

Plan Name _____

I.D. Number: _____ Group Number: _____

Claims Address: _____

Phone Number :( ) - _____

Policy Holder's Social Security Number: _____

Secondary Insurance

Plan Name _____

I.D. Number: _____ Group Number: _____

Claims Address: _____

Phone Number :( ) - _____

Policy Holder's Social Security Number: _____

Third Insurance

Plan Name _____

I.D. Number: _____ Group Number: _____

Claims Address: _____

Phone Number :(____) _____ - _____

Policy Holder's Social Security Number: ____ - _____ - ___

Is the patient enrolled in Hospice? Yes ____ No_____ .

Is this visit due to a job related injury or automobile accident? If so please notify the receptionist.

I hereby authorize Atlanta Eye Consultants, P.C. to release any medical information necessary to process

bills to my insurance company. I acknowledge that I am financially responsible for any amount that is not covered by my insurance company.

Patient Signature/ Responsible Party: _____ Date: _____

Registration

Name:

What is the primary reason for today's (first) visit?

Do you currently have any problems in the following areas? If "YES", give an explanation.

Eyes

Loss or blurred vision yes [ ] no [ ]

Loss of side vision, double vision yes [] no [ ]_____

Itching, burning, or discharge yes [] no [ ]_____

Redness yes [] no [ ]_____

Gritty feeling, dryness or tearing Glare/light yes [ ] no[ ]

sensitivity, or halos yes [] no [ ]_____

Eye pain or soreness yes [] no [ ]_____

Infection of eye lashes or lid, styes yes [] no [ ]_____

Cardiovascular (heart, blood vessels) yes [ ] no [ ]

Respiratory (lungs/breathing)

Gastrointestinal (stomach/intestines) **yes** [ ] no[ ]

Musculoskeletal (muscles/joints) **yes** [ ] **yes** [ ] no[ ]

Endocrine (hormones, glands) **yes** [ ] no [ ]_____

Seasonal allergies (hay fever, etc.) yes [ ] no [ ]_____

PAST HISTORY (EYE) no [ ]_____

Eye drops currently in use:

Allergies to eye drops _____

History of cataract, glaucoma

History of crossed/lazy eye

Eye injury or other disease

Eye surgery (date)

PAST HISTORY (GENERAL)

List any medications (other than eye drops) that you are currently using:

List all major illnesses: Diabetes Hypertension

List any major surgical procedures with dates:

Do you have any medication allergies? [ ] NO [ ] YES

List other allergies:

FAMILY HISTORY

OCULAR

Blindness

Cataract

Glaucoma

Macular degeneration Retinal

detachment **MEDICAL**

HISTORY

Diabetes
Arthritis, lupus, etc.
Other (list)

OCULAR

Have you ever worn wear contact lenses? _____

Did you have problems with contact lenses? _____

Vision causes problems with:

□ Driving □ Night vision □ Reading □ Sports/Outdoor activities

SOCIAL HISTORY

Do you drink alcohol? _ How much per day? _____

Do you smoke? ___ How many packs per day?

Have you ever had a blood transfusion? __ When? _____

History reviewed [ ] No changes [ ] Additions as noted

Physician's signature:_____ Date: