HUGO OPTICAL
REGISTRATION FORM

PATIENT INFORMATION

Patient's first name:	Last name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Home Phone: ( )	Work Phone: ( )	E-mail:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Apt#

City:	State:	ZIP Code:

Occupation:	Employer:

Chose clinic because/Referred to by *(please check one box):*	❑ Insurance Plan	❑ Yellow Pages

❑ Family	❑ Friend -	❑ Close to home/work	❑ Other

Other family members seen here:

MEDICAL HISTORY

Date of last exam: / /	What is your reason for seeking eye care at this time?

Do you wear contact lenses? ❑ Yes ❑ No	How many hours per day do you wear your contacts?

What type of Contacts do you wear? *(check all that apply)*	❑ Soft lenses	❑ Toric	❑ Disposable
	❑ Rigid gas permeable	❑ Daily wear (daytime only)	❑ Extended wear (sleep in)

How often do you change your contact lenses?

Do you or your family members have any of the following? *If so, please list who:*

❑ High blood pressure	❑ Diabetes	❑ Allergies	❑ Thyroid problem	❑ Strabismus (eye turn)
❑ Glaucoma	❑ Retina Disease	❑ Cataract	❑ Amblyopia (lazy eye)	❑ Macular Degeneration

Have you ever experienced? *(check all that apply)*

❑ Color vision problems	❑ Double vision	❑ Flashes of light	❑ Floaters
❑ Night vision problems	❑ Eye infection	❑ Eye surgery	❑ Frequent headaches

How many hours do you work on computer per day?

Do you smoke? ❑ Yes ❑ No	(Women only) Are you pregnant or nursing? ❑ Yes ❑ No

ARE YOU CURRENTLY TAKING ANY MEDICATION? *(Please list)*

DILATION INFORMATION

To provide the most complete evaluation of your eyes it is sometimes necessary to administer drops to dilate your pupils. Dr. Petronack will discuss how the dilation may temporarily affect you vision. *Please check one of the following:*

❑ I give my permission to have my eyes dilated	❑ I am undecided and would like to discuss	❑ I have read & understand the importance of dilation, but refuse procedure

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Insurance Provider:	Policy Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hugo Optical or insurance company to release any information required to process my claims. We have a comprehensive "notice of privacy practices" that describes the use and disclosure of your personal medical information in detail as per federal law. I understand these policies are posted at the front desk and are available as individual copies for my use.

Patient/Guardian signature ***Date***