Lakeway Eye Physicians and Surgeons, P.A.
Corina A. Stancey, MD
1007 RR 620 South, Suite 100, Lakeway, TX 78734
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PATIENT REGISTRATION FORM

Name: ____ **Social Security #:** ______________________________

Phone #: ____________ **Cell** ☐ **Landline** ☐ **Phone #** _____________ **Cell** ☐ **Landline** ☐

E-mail Address: ____

Address: ____
Street City State Zip

Date of Birth: ___/___/_______ **Age:** _____

Sex: M F **Marital Status:** S M D W

Employer: ______________________________________ ________________ ______ _______________
Name City State Zip

Occupation: ___________________________________ **Office Phone:** _____________________________

Primary Care Physician: ______________________ **Optometrist:** ___________________________________

Referral Source: ☐ Doctor ☐ Yelp ☐ Drive By ☐ Insurance List
☐ Friend/Family ☐ Google/Search ☐ Community Impact ☐ Other:____________________

Primary Insurance Carrier: ____

Subscriber's Name: _______________________________ **Subscriber's Date of Birth:** _______________

Subscriber's Soc. Sec. #: ________________________ **Relationship to Patient:** ____________________

- **Secondary Insurance Carrier:** ____

Subscriber's Name: _______________________________ **Subscriber's Date of Birth:** ______________

Subscriber's Soc. Sec. #: ________________________ **Relationship to Patient:** ____________________

Guarantor (The person responsible for payment if not the patient): _______________________________

Address____

Guarantor Date of Birth:____________**Guarantor's Soc Sec #**__________________________________

Emergency Contact Name: ____________________________ **Telephone #:** _______________________

*****ALL PAYMENTS AND CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE*****

PATIENT MEDICAL HISTORY **Date: ____________________**

Name: _________________________________ Date of Birth: _____________

Are you ALLERGIC to any medications (Describe)? Y N____

Are you currently taking ANY medications (Describe)? Y N____

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Are you currently taking any EYE medications (Describe)? Y N____

Do you wear glasses? Y N Do you wear contact lenses? Y N soft ☐ hard ☐

Do you have any history of eye disease (Describe)? Y N ____

Have you ever had an eye injury or eye surgery? (Describe & include year) Y N __________________________________

Do you have or have you had any of the following conditions or problems? (PLEASE CIRCLE)

- **Constitutional: weight loss/gain, fatigue, etc.**
- **Ear/Nose/Throat: hearing loss, sinus problems**
- **Cardiovascular: high blood pressure, heart problems, heart attacks, pacemaker**
- **Endocrine: diabetes, thyroid problems, Graves disease**
- **Hematologic/Lymphatic: HIV+, AIDS, hepatitis, high cholesterol**
- **Respiratory: asthma, emphysema, bronchitis, tuberculosis**
- **Gastrointestinal: heartburn, ulcer**
- **Integumentary: rashes, rosacea, breast problems, healing problems/keloid formation**
- **Musculoskeletal: arthritis, lupus, gout, osteoporosis**
- **Neurological: headaches, stroke, multiple sclerosis, paralysis**
- **Psychiatric: depression, anxiety, claustrophobia**
- **Allergic/Immunologic: seasonal allergies, hay fever**

Have you ever had any head injuries? (Describe & include year) Y N ____

Have you ever had other surgeries (not including eyes)? (Describe & include year) Y N____________________________
____

Do you have any FAMILY HISTORY of the following? If so, please list relationship (mother, grandfather, etc.)

Y N Blindness: _________________________________ Y N Cancer: ___________________________

Y N Cataracts: _________________________________ Y N Diabetes: __________________________

Y N Diabetic Retinopathy: ______________________ Y N Heart Disease: _____________________

Y N Glaucoma: _________________________________ Y N High Blood Pressure: _______________

Y N Macular Degeneration: ______________________ Y N Stroke: ____________________________

Y N Retinal Detachment: _______________________ Y N Other (explain): ____________________

Are you currently a smoker? Y N Former Smoker? Y N

Number of years and amount per day: ____________________

Do you drink alcohol? ☐ none ☐ rarely ☐ socially ☐ daily: drinks per day: ____

Physician's Signature: **____** ***Date:*** **______________________**