Kentucky Pediatric Ophthalmology & Strabismus (KPOS)
New Patient Registration Form - Adult

(Please print and complete both sides of this form)

PATIENT INFORMATION

Patient Name: ____**Date of Birth:** _____________

Age: ____________________**Sex:** _______________ **Phone:** _________________________

Address: ____

City: ____________________________________**State:** _____________ **Zip:** ___________

Email:____

REFERRING & PRIMARY CARE PHYSICIAN INFORMATION

Referring Physician's Name: ____________________________ **Phone:** ________________

Primary Care Physician's Name: _________________________ **Phone:** ________________

INSURANCE GUARANTOR'S INFORMATION (the person who carries the insurance)

Guarantor's Name: ___________________________________ **SSN:** ___________________

Relationship to patient: _______________________________ **DOB:** __________________

Employer: ____**Phone:** __________________

Employer's Address: ____

City: ___________________________________ **State:** ____________ **Zip:** ______________

EMERGENCY CONTACT INFORMATION

Contact's Name: ______________________________**Relationship to patient:** _________

Home Phone: _________________________ **Work Phone:** ___________________________

ACCIDENT INFORMATION

Is this visit accident related? YES NO (If yes, please fill out below)

Date of Accident: ___________ **Time of Accident:** ________ **Place of Accident:** _________

Nature of Accident: ____

NEW PATIENT QUESTIONS

Does anyone smoke in the house? YES NO

Last grade completed? ______________________________

Has the patient had any previous eye problems? ______________________________

____

Does the patient have a family history of:

			(Who)				(Who)
Crossed Eyes	YES	NO	______	Eye Surgery	YES	NO	______
Lazy Eyes	YES	NO	______	Other Eye Problems	YES	NO	______

Has the patient had any problems with the following:

Fever	YES	NO	Stomach or Intestine	YES	NO
Weight Loss	YES	NO	Urinary System or Bladder	YES	NO
Allergies	YES	NO	Joint, Bone, or Muscles	YES	NO
Skin Rash	YES	NO	Glands (endocrine, diabetes or thyroid)	YES	NO
Ear, Nose or Throat	YES	NO	Blood Diseases	YES	NO
Breathing/ Asthma	YES	NO	Growth or Neurologic Dev.	YES	NO
Heart	YES	NO	Emotions or Behavior	YES	NO

PAST MEDICAL HISTORY

Please list all medical problems, major illnesses, hospitalizations, or surgeries:

____

____

____

____

Please list all medications the patient is currently taking (including eye drops):

____

____

____

Any allergies to medications? YES NO (if YES, please list below)

____

Reason for today's visit:

____

____

Patient Signature: ______________________________ Date: __________

Physician's Signature: ______________________________ Date: __________