Kay, Tabas & Niknam Ophthalmology Associates
Registration Form
(Please Print)

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Dr. ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No. & Cell Number ( ) ( ) CELL

P.O. Box	City	State	ZIP Code

E-MAIL ADDRESS (to receive our informative quarterly newsletter):	OCCUPATION: EMPLOYER:	Employer Phone No. ( )

Chose KTOA Because/Referred to KTOA by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

Primary Physicians Name: _____ Primary Physicians Phone Number: _____
Address: _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Is this person a patient here?	❑ Yes ❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No.

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

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 Kay & Tabas Ophthalmology Associates or insurance company to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE DATE

PATIENT'S NAME: _____ DATE OF BIRTH:_____

Please list any past and present eye problems. (Describe present symptoms; list any previous eye surgery with approximate dates.)

List all **EYE** medications and describe how they are being used and in which eye:

Do you smoke? _____ If so, how much? _____
Do you drink? _____ If so, how much? _____

List any family history of eye problems (i.e. glaucoma, retinal problems, cataracts, eye muscle problems, etc.)

Do you wear glasses? _____ How long have you worn glasses? _____

How old is your present prescription? _____

Do you wear contact lenses? _____ How long have you worn contact lenses? _____

What type of lenses do you wear? _____ How old is your present prescription? _____

Are you **ALLERGIC** to any drugs or medications? (Please list names)

Do you have any of the following conditions: (all information will be confidential)

DIABETES/HOW LONG? _____HEART PROB.? _____ HIGH BLOOD PRESSURE? _____
HIV POSITIVE? _____ Any other medical conditions? _____

REVIEW OF SYSTEMS – Please circle if you have any of these problems.	
GI	**Nausea/ vomiting/ diarrhea/ weight loss/ appetite loss/ blood in stools**
HEART/LUNG	**Asthma/ chest pain/ shortness of breath/ cough/ irregular heart beat**
GU	**Pain on urination/ blood in urine/ incontinence/ discharge**
HEENT	**Headaches/ hearing loss/ sore throat/ voice change**
SKELETAL	**Joint pain/ muscle pain/ back pain/ range of motion restriction**
SKIN	**Rashes/ bruises/ new skin lesions**
NEURO	**Headache/ blackouts/ seizures/ dizziness/ numbness or tingling**
ENDOCRINE	**Thyroid/ excessive thirst or urination/ hot or cold intolerance**

List any medications that you may be taking (other than eye medications):
_____

List any major surgery (other than eye surgery and include approximate dates):
_____