Hi-Line Eye Care, PLLC

234 5th St S, Glasgow, MT 59230 - Phone:(406) 228-4895

Registration Form

PATIENT INFORMATION

Patient's First Name Middle Last (Legal Name)	Sex ☐ Male ☐ Female	Date of Birth Age	Nickname	Former Name

Address, City, State, Zip	Home Ph: _____ Work Ph: _____ Cell Ph: (Circle Best Contact #)	Vision Insurance Yes / No Medical Insurance Yes / No Social Security # _____ (SS# needed to check insurance eligibility)

If patient is a minor, name of person responsible for payment:	Address if different from above:
How did you hear about us?	email address:

PATIENT HISTORY

Do you have? (please check all that apply

☐ Dry Eyes ☐ Blurred Vision ☐ Watery Eyes
☐ Floaters ☐ Double Vision ☐ Severe or frequent headaches
☐ Itchy Eyes ☐ Flashes of LIght
☐ Fatigue/Strain when reading or looking at computer

Date of Last Eye Exam: _____

Date of Last Physical: _____

Name of your Primary Care Physician: _____

Do you or any of your blood relatives have? (please check and/or circle all that apply)

	Self	Blood Relative		Self	Blood Relative
Retinal/macular disease	☐	F M B S	High Blood Pressure	☐	F M B S
Glaucoma	☐	F M B S	Thyroid Problems	☐	F M B S
Diabetes	☐	F M B S	Asthma	☐	F M B S
High Cholesterol	☐	F M B S	Heart Disease	☐	F M B S

Are you taking any Medications? If yes, please list: _____

_____

Are you allergic to any medications? If yes, please list: _____

_____

Have you ever had any eye disease, injury, or surgery? If yes, please list: _____

_____

Are you pregnant? No Yes Circle one or both, if you smoke / drink? If yes, how often? _____

PATIENT / PARENT / GUARDIAN SIGNATURES

I acknowldege the receipt of the HIPAA Privacy Notice:

_____ _____

Patient or if a minor Parent/Guardian Signature Date

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 Hi-Line Eye Care, PLLC or insurance company to release any information required to process my claims.

_____ _____

Patient or if a minor Parent/Guardian Signature Date