Everett Vision Therapy

REGISTRATION FORM-ADULT

PATIENT INFORMATION

Name (First, Last): ____

Date of Birth:______/_______/_____ **Age:**________ **Gender:** **Female** **Male**

Address:____

City/State/Zip code: ____

Phone number: _________________________________ **Email:** ___________________________________

Emergency contact name & number: ____

Did anyone refer you to us? (please list name/office):

____

FAMILY BACKGROUND

Please list other individuals in your household (spouse, children, parents):

____

____

____

Please indicate any family history of the following:

Lazy eye	______________________________	**Diabetes**	____________________________
Eye turn	______________________________	**Hypertension**	____________________________
Colorblindness	______________________________	**Migraines**	____________________________
Cataracts	______________________________	**Anxiety**	____________________________
Glaucoma	______________________________	**ADHD**	____________________________
Retinal disease	______________________________		

MEDICAL HISTORY

VISUAL HEALTH

Last eye exam:______/________/______ **Last dilation:______/_______/________**

Facility/Doctor's name: ________________________________

Please list any vision related conditions you have been previously diagnosed with:

____

Please indicate if you wear glasses or contact lenses? ____

GENERAL HEALTH

Last physical exam: _____/______/______

Facility/Doctor's name: ____

Please list any conditions you have been diagnosed with: _____________________________________

____

Please list any medications you are currently taking and for what condition:

____

____

____

____

____

Have you ever had concussion or head injury? If yes, please indicate what age and a brief description and any treatment services you have received

____

____

____

Please list any allergies:

____

____

OCCUPATION/HOBBIES

Do you currently work? ___ Full-time ___ Part-time ___ Retired ___ Student

Occupation: _________________________

Please indicate any aspects of your job that are particularly challenging or visually stressful:

____

____

How many hours per day do you spend on a computer/electronic device? _____________

On average, how many hours of sleep would you say you get per night? _______________

What hobbies do you like to participate in?

____

____

Everett Vision Therapy

SYMPTOM SURVEY

Patient Name: ___________________________________ Date: ____________________

Please rate the following symptoms as 0 = never, 1 = occasionally, 2 = often, 3 = always.

1. **Blur when looking at near** _____
2. **Headaches with near work** _____
3. **Dizziness or nausea with near work** _____
4. **Avoids near work/reading** _____
5. **Difficulty copying from board to paper** _____
6. **Double vision** _____
7. **Words moving or overlapping on a page** _____
8. **Skips or repeats lines when reading** _____
9. **Misaligns digits/columns of numbers** _____
10. **Closes one eye or tilts head while reading** _____
11. **Poor reading comprehension** _____
12. **Trouble keeping attention on reading** _____
13. **Prefers being read to rather than reading** _____
14. **Difficulty with sight word recognition** _____
15. **Poor spelling ability** _____
16. **Reversals letters such as b/d/p/q** _____
17. **Poor handwriting** _____
18. **Poor hand-eye coordination** _____
19. **Clumpsiness/knocks things over** _____
20. **Takes longer than expected to complete assignments** _____

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to make available to you a copy of our Notice of Privacy Practices, which states how we may use and /or disclose your health information. You are entitled to a copy of our Notice of Privacy Practices, which is available in our office. Please let us know if you would like to have a copy of Everett Vision Therapy Privacy Practices.

I also give my consent for Everett Vision Therapy to communicate appointment reminders and forms via email/text unless indicated otherwise below.

☐ **I do NOT want to receive communication from Everett Vision Therapy via email or text.**

____

Print name of patient

____

Signature of patient (or parent/guardian if patient is a minor)

____

Print name of parent/guardian (if signing for a minor)

____

Date

INSURANCE CLAIM AUTHORIZATION FORM

____

By signing this statement, you are authorizing Everett Vision Therapy to complete any necessary insurance claim forms on your behalf. You are hereby also authorizing the release of any medical or other relevant information which may be needed in order to process your claims. Your signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services you have received.

____

Patient Name

____

Name of Policy holder (if different from patient)

____

Policy holder DOB (MM/DD/YYYY)

____

Signature of Patient/Authorized Person

____

Date

Everett Vision Therapy

MEDICAL RECORD RELEASE FORM

PATIENT NAME: ____

DATE OF BIRTH: _________________________________

This document allows Everett Vision Therapy to release the medical records of the above mentioned patients to the parties specified below.

1. **Optometrist:** ____

   Address: ____

   Phone: _________________________________ **Fax:** _________________________________

   Email: ______________________________________

2. **OT/PT/SPEECH therapist:** ____

   Address: ____

   Phone: _________________________________ **Fax:** _________________________________

   Email: ______________________________________

3. **Teacher:** ____

   Address: ____

   Phone: _________________________________ **Fax:** _________________________________

   Email: ______________________________________

4. **Physician:** ____

   Address: ____

   Phone: _________________________________ **Fax:** _________________________________

   Email: ______________________________________

SIGNATURE: ____ **DATE:** ________________________

Patient/guardian

PRINTED NAME: ____