



Registration Form

Contact Information			
Last Name:		First & Middle Name	
Address	City	State	Zip
Date of Birth: / /	Age:	Sex: M F	
Cell Phone	Home Phone:	Work Phone:	
E-mail:			
Occupation:		Employer:	
Emergency Contact:			
Do you have medical insurance? Yes No If Yes, please give us the name and the policy No. below			
The Name of Insurance Company:		Policy No.#	
When was your last eye exam?			
Any finding / Treatments??			
How did you hear about us?			

Medical History						
List any medications you take (including oral contraceptives):						
Are you allergic to any medications?					Yes	No
If yes, list and Explain:						
Are you currently being treated for any medical condition?					Yes	No
If yes, Explain:						
Are you pregnant or nursing?					Yes	No
Have you ever had or been told that you have:						
General Eye Conditions	Yes	No	General Health Conditions	Yes	No	
Glaucoma			Diabetes			
Cataracts			Thyroid			
Retinal Detachment/Disease			Heart Disease			
Lazy Eye/Amblyopia			Breathing Problems			
Eye Surgery			Auto-Immune Disease			
Dry Eye			Arthritis			
Eye Injury/Infection			High Blood Pressure			
Explain "Yes" Above or List other Condition(s):						

Thank You for choosing CCRS!