



Dr. Marlan Anderson, Dr. Richard Bell, Dr. Edward Carl Elder, Dr. Kenneth Pierson & Associates
Therapeutic Optometrists, Optometric Glaucoma Specialists

PATIENT REGISTRATION AND HEALTH HISTORY FORM

Date _____ Patient Name _____

Parent or Responsible Person _____ Patient Age _____ DOB _____
(if patient is a minor)

Mailing Address _____ Phone # _____ Wk# _____ Cell # _____

(City) (State) (Zip Code)

E-mail address _____ Patient Occupation _____

Employer _____ Grade if student _____ School _____

Social Security # _____ Drivers License # _____ State _____

Vision Plan: _____ (if using insurance) _____ (if paying by check)

Medical Insurance; _____

How did you find out about our office? (please fill in for advertising purposes)

I would like an eye examination for (circle one): glasses contact lenses laser vision correction

Other (please explain) _____

Date of last eye exam _____ Dr: _____

Are you pregnant at this time? _____ How long? _____

List any health problems _____

List any medicines you are taking and why _____

Do you have a history of tobacco / alcohol or substance abuse? _____

List any medicines you are allergic to _____

Does anyone in your family have glaucoma, cataracts, macular degeneration, diabetes, hypertension, or any other diseases? Is so, what and whom? _____

Do you ever experience any of the following eye health symptoms?

- ___ dryness of eye ___ watering ___ decreased vision ___ glare ___ mucous discharge
- ___ flashing lights ___ fluctuating vision ___ tired eyes ___ gritty feeling ___ floaters
- ___ vision loss ___ lazy eye ___ itching ___ eye pain ___ headaches ___ infection(s)
- ___ burning ___ redness ___ dizziness other _____

(PLEASE COMPLETE THE BACK SIDE ALSO)



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ACKNOWLEDGMENT OF RECEIPT

- I have acknowledged that I have received and read the Notices of Privacy Practices of Eyetx Vision Centers

- I have received, but not read the Notice of Privacy Practices of Eyetx Vision Centers, but would like to continue my eye care at this office

- I will not sign the Notice of Privacy Practices of Eyetx Vision Centers and choose to seek another eye care provider

- Due to extenuating circumstance, I am unable to sign the form at this time, but would like to continue my eye care at this time

Patient name: _____
(please print)

Patient signature: _____
(parent of guardian, if patient is a minor)

Date: _____