# Arinella-Williams, LLC
## PATIENT REGISTRATION

Name: _____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel. Home: _____ Work: _____ Cell: _____

Marital Status: _____ Male: _____ Female _____

Email Address:

_____

Race: (Please Circle) American Indian; Alaskan Native; Asian; Black or African American;
Native Hawaiian or Other Pacific Islander; White

Ethnicity: (Please Circle) Hispanic or Latino; Non-Hispanic/Non-Latino

**Emergency Contact**: _____ Phone #: _____

Relationship: _____

**Primary Care Physician**:

Name: _____

Address: _____

**If Diabetic who do you see PCP or Endocrinologist**: _____

Who may we thank for referring you:

Name: _____

Address: _____

I hereby authorize Arinella-Williams, LLC to administer such treatment as may be deemed necessary or advisable in the care of:

_____

Guardian's Signature: _____ Relationship: _____

## ALL PATIENTS

I authorize the release of any payment and medical information necessary to process this and any related claims.
I certify that the above information is correct.

Signature: _____ Date _____

# Medical History Questionnaire

Name _____ Date _____

Date of **Birth** _____ Date of **last eye exam** _____

List any **medications** you currently take (Rx and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES** **NO**
If YES, list the medications: _____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

| | YES | NO | DETAILS |
|---|---|---|---|
| **EYES** (poor vision, eye pain, tearing, redness, etc.) | | | |
| **GENERAL/CONSTITUTIONAL** (fever, heat stroke, weight loss, weight gain, unusually tired) | | | |
| **EARS, NOSE, THROAT** (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.) | | | |
| **CARDIOVASCULAR** (high BP, racing pulse, etc.) | | | |
| **RESPIRATORY** (congestion, wheezing, short of breath, etc) | | | |
| **GASTROINTESTINAL** (stomach upset, diarrhea, constipation, hernia, ulcers, etc.) | | | |
| **GENITAL, KIDNEY, BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.) | | | |
| **FEMALES** Are you pregnant? Nursing? | | | |
| **MUSCLES, BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.) | | | |
| **SKIN** (pimples, warts, growths, rash, etc.) | | | |
| **NEUROLOGICAL** (numbness, headache, seizures, paralysis, etc.) | | | |
| **PSYCHIATRIC** (anxiety, depression, insomnia) | | | |
| **ENDOCRINE** (diabetes, hypothyroid, etc.) | | | |
| **BLOOD/LYMPH** (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.) | | | |
| **ALLERGIC/IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, etc.) | | | |

## FAMILY HISTORY

**(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

**Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis**
Other heritable disease: _____

## SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**

Have you ever had a blood transfusion? **YES** **NO**

Do you drink alcohol? **YES** **NO** If YES, how much? _____

Do you smoke? **YES** **NO** If YES, how much? _____ How many years? _____

*Physician's Signature* _____ *Date* _____

# ACKNOWLEDGMENT

I, _____, acknowledge that I may have a copy of The HIPPA Notice of Privacy Practices for Joseph Williams, M.D. and Arinella-Williams, LLC upon request.

Date:_____ Signed: _____