

# John J. Riggs Office of Optometry - Patient Registration Record

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Address: \_\_\_\_\_ Age: \_\_\_\_\_  
 City/State/Zip Code: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Business/Daytime Phone: ( ) \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Hobbies: \_\_\_\_\_  
 Person responsible for payment if different than patient: \_\_\_\_\_

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Name \_\_\_\_\_ Address \_\_\_\_\_ Daytime and Home Phone \_\_\_\_\_

**Vision Insurance:**

Medi-Cal No  Yes  ID Number: \_\_\_\_\_  
 Medicare No  Yes  ID Number: \_\_\_\_\_  
 VSP No  Yes  ID Number: \_\_\_\_\_  
 Other: \_\_\_\_\_ ID Number: \_\_\_\_\_  
 Do not have vision insurance

Method of Payment: Cash  Check  Credit Card

Do you or anyone in your family have a history of any of the following? Please state the relationship to the patient. (e.g.: self, mother, father, grandmother, grandfather, etc.)

High Blood Pressure	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	_____	Thyroid Disease	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	_____	Eye Injury	<input type="checkbox"/>	_____
Eye Turns	<input type="checkbox"/>	_____	Eye Operations	<input type="checkbox"/>	_____
Eye Infections	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	_____
Other:		_____			_____

Please list any medications you are now taking: \_\_\_\_\_

Are you allergic to any medications? If yes, which: \_\_\_\_\_

Do you use cigarettes/tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Other substance(s)? \_\_\_\_\_

What is the nature of your visual difficulty? (Or is this visit for a regular annual exam?) \_\_\_\_\_

Your previous eye practitioner was \_\_\_\_\_ OD  MD

When was your last eye exam? \_\_\_\_\_ years ago.

In case of an emergency, please contact:

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Name \_\_\_\_\_ Relation \_\_\_\_\_ Address \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

**Assignment of Benefits/Financial Agreement**

I hereby give authorization for payment of insurance benefits to be made to John J. Riggs, O.D. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, 1.5 % per month finance charge, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure all payment of benefits. I understand that replacement of a frame(s) under warranty is subject to a shipping/handling fee. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_