

**Louis I. Sobel MD**  
**OPHTHALMOLOGY**  
 30 East 76<sup>th</sup> Street 3<sup>rd</sup> Floor  
 New York, NY 10021  
**REGISTRATION FORM**  
 (Please Print)

**PATIENT INFORMATION**

Last name:		First:		Middle:	
Date of Birth:	Age:	Social Security #:		Gender:	
Home address:			P.O. box/Apt.:		
City:		State:		ZIP Code:	
Cellular Phone:		Home Phone:		Work Phone:	
email:			Preferred method of contact:		
Occupation:		Employer:		Employer Address:	
Primary Care Physician:			Phone:		
Who referred you to this practice:					
Emergency Contact:		Phone:		Relation:	

**INSURANCE INFORMATION**

(Please give your Insurance card and Photo ID to the receptionist)

Subscriber's name:		Birth date:		Subscriber's S.S. #:	
Primary Insurance:			Secondary Insurance (if applicable):		
Patient's relationship to subscriber:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Please indicate Vision insurance:	<input type="checkbox"/> VSP	<input type="checkbox"/> DAVIS VISION	<input type="checkbox"/> EYE MED	<input type="checkbox"/> VISION CARE PLAN	

**PERSONAL HEALTH HISTORY**

What is your eye problem?					
When did you first notice this problem?			Have you had any history of other eye problems?		
Does anyone in your immediate family have a chronic eye disease? If so list:					
Are you taking any medication for your eyes?					
Check all that apply:	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataract	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Diabetic Eye Disease	<input type="checkbox"/> Dry Eye
Do you wear glasses? Reading? <input type="checkbox"/> Distance? <input type="checkbox"/>		Do you wear contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No Brand:		Contact Prescription: Right eye _____ Left eye _____	

**LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED**

Check all that apply:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cardiac Disease	<input type="checkbox"/> Cancer, Form:	<input type="checkbox"/> Other
Are you being treated by a physician? If yes, explain:					
Women only: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No			List any hormones or birth control pills:		
Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason:	Year:	Hospital:	
Hospitalizations:					

**LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER MEDICATIONS/SUPPLEMENTS**

Name/Dosage:	Name/Dosage:	Name/Dosage:
Name/Dosage:	Name/Dosage:	Name/Dosage:

Allergies to medications? If so name:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Louis I. Sobel, MD or insurance company to release any information required to process my claim.

Patient/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_