Susan M. Longar, MD
1850 Sullivan Ave, Suite 500
Daly City, CA 94015

PATIENT REGISTRATION FORM

Date_____ Home phone_____ Cell phone_____

Name_____ Soc. Sec. No._____
Last name First name Initial
Address_____ City_____ State_____ Zip Code_____

Primary Doctor_____ Referred By_____

Sex ☐ M ☐ F Age_____ Birthday_____ ☐ Single ☐ Married ☐Widowed ☐Separated ☐ Divorced

Race **(please select one)** ☐ White ☐ Black ☐ Native American/Eskimo ☐ Asian/ Pacific Islander ☐Other_____

Ethnicity **(please select one)** ☐ Hispanic ☐Mexican ☐Puerto Rican ☐ Cuban ☐ Central or South American ☐or other Spanish culture or origin. Please specify_____

Patient Employed By_____ _____Occupation_____

Business Address_____Business Phone _____

Email _____ Primary Language_____

In case of emergency who should we notify? _____Relation_____

PRIMARY INSURANCE

Name of Primary Insurance _____ Medical Group if HMO _____

Subscriber No. _____ Group No. _____

Worker Comp ☐Yes ☐No Insurance Name_____ Policy No._____

Eye Vision Plan (VSP /MES) Soc. Sec. No. of subscriber _____ DOB_____

Person Responsible for Account _____Relation to Patient_____

Address **(if different from patient)** _____ City _____ State _____

Zip Code _____ Birthdate_____ Soc. Sec. No. _____

Employed By _____Occupation _____

Business Address_____ Business Phone _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No
Insurance Name _____ Subscriber No. _____ Group No. _____

Person Responsible for Account _____ Relation to Patient_____
Address **(if different from patient)** _____ City _____ State _____ Zip Code_____

MEDICAL HISTORY

GENERAL HEALTH

☐ Diabetes ☐ High blood pressure ☐ High Cholesterol ☐ HIV ☐ Heart attack

☐ Arthritis ☐ Cancer_____ ☐ Asthma ☐ Pregnant ☐Thyroid disease

☐ Bleeding problem ☐ TB (active / not active ☐ Stroke ☐ Angina ☐ Sinus problems

☐ Lung disease ☐ Neurological problems ☐ Injury (bodily) or Injury (eye) _____

☐Other _____

EYE HEALTH

☐ Cataract (if you had surgery what year) _____ Surgeon _____ ☐ Eye trauma _____

☐ Macular degeneration ☐ Retinal detachment ☐ Glaucoma ☐ Diabetic retinopathy

☐ LASIK/PRK or any other Eye surgery _____ **Risk Factors** ☐Do you smoke? ☐Do you drink? ☐Work around machinery?

Date of Last Eye Exam and Name of MD/OD _____

FAMILY HISTORY

☐ Cataract _____ ☐ Glaucoma_____ ☐ Macular degeneration_____

☐ Retinal detachment_____ ☐ Diabetic retinopathy_____ ☐ Strabismus_____

PLEASE LIST MEDICATIONS:

EYE MEDICATIONS:

IF YOU ARE TAKING FLOMAX, Please mention to your Medical Assistant or Doctor

ALLERGY TO MEDICATIONS AND REACTION:

By signing below, I authorize my insurance benefits to be paid directly to the doctor and agree that I will be responsible for any **non-covered** services. I authorize my physician(s) and /or their agents to release any information to my insurance company to process claims for my care.

SIGNATURE _____ DATE_____

RESPONSIBLE PARTY (if not patient) _____

RELATIONSHIP _____

AFTER COMPLETION PLEASE HAVE YOUR INSURANCE CARD AND ID AVALIABE FOR THE RECEPTIONIST