PORT HURON EYE CARE
Fahim K. Ibrahim, MD, PC Kamal Fahim, MD, PLC
4190 24th Avenue, Suite 204
Fort Gratiot, MI 48059
PATIENT REGISTRATION FORM

PATIENT NAME:_____DOB: _____/_____/_____
Last First

SOCIAL SECURITY #:_____-_____-_____ MARITAL STATUS_____ SEX_____

HOME ADDRESS:_____
Street City State Zip
HOME PHONE_____WORK PHONE_____

CELL PHONE:_____EMAIL ADDRESS_____

RACE:_____LANGUAGE: _____ ETHNICITY: _____

SPOUSE NAME:_____DOB (SPOUSE)_____/_____/_____

EMERGENCY CONTACT:_____RELATIONSHIP:_____

EMERGENCT CONTACT PHONE:_____

FAMILY PHYSICIAN:_____PHONE:_____

REFERRED BY:_____

PHARMACY NAME: _____

PHARMACY LOCATION: _____

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received by Port Huron Eye Care (Fahim Ibrahim, MD, PC and/or Kamal Fahim, MD, PLC) whether covered by my insurance or not.

I understand that Port Huron Eye Care is filing the claims on my behalf but does not mean that they participate with my insurance company and therefore I may still be responsible for payment in full at
the time of service.

I understand that for an eye examination or testing, my eyes will be dilated which may interfere with my vision while walking or driving. It is my sole responsibility to have an escort and also to use sunglasses if needed. Port Huron Eye Care will not be liable if I become involved in any accident or injury to others or myself.

This is to acknowledge that I have been informed about and offered a copy of Port Huron Eye Care Notice of Privacy Practices. I understand the above, any questions that I have were answered.

PATIENT SIGNATURE:_____DATE:_____

Port Huron Eye Care
History Questionnaire

Height: _____ Weight: _____ Last Blood Pressure: _____

Eye Problems:	Review of Systems:	Family History:
☐ Blurry Vision	☐ Consitutional (fatigue, fever)	☐ Lazy Eye
☐ Burning	☐ Respiratory (asthma, cough)	☐ Blindness
☐ Double Vision	☐ Cardiovascular (chest pain, leg swelling)	☐ Cataracts
☐ Drooping Eye Lid	☐ Gastrointestinal (constipation, nausea/vomiting)	☐ Glaucoma
☐ Eyelid Lesion	☐ Genitourinary (urinary infections)	☐ Macular Degeneration
☐ Flashes & Floaters	☐ Metabolic/Endocrine (heat/cold intolerance)	☐ Retinal Disorders
☐ Foreign Body Sensation	☐ Neurological (weakness, headache)	☐ Strabismus
☐ Glare	☐ Psychiatric (depressed mood, stress)	☐ High Blood Pressure
☐ Irritation	☐ Integumentary (skin rash)	☐ Diabetes
☐ Pain	☐ Musculoskeletal (muscle/joint pain)	☐ Heart Disease
☐ Red Eye	☐ Hematologic/lymphatic (bleeding/brusing)	☐ Arthritis
☐ Tearing	☐ Immunologic (food/seasonal allergies)	☐

Ocular Medications (Eye Drops/Ointment):

Allergies to Medications:

☐ No Known Allergies

Please List Current Medications:

Medical Illnesses:

☐ Diabetes
☐ High Blood Pressure
☐ Other:

Past Surgeries (including eye surgeries):

Smoking Status:

☐ Current Smoker ☐ Former Smoker ☐ Never Smoked ___ Packs Per Day

Alcohol Use:

☐ Frequently ☐ Occasionally ☐ Rarely

Caffeine Use:

____ Cups Per Day