



PATIENT REGISTRATION

Date _____ / ____ / _____

Patient Information

Last Name _____ Driver's License # _____
 First Name _____ M.I. _____ Home Phone (____) _____
 Street Address _____ Work Phone (____) _____
 City _____ State _____ Zip _____ Date of Birth _____ / ____ / ____
 Employer _____ Social Sec # _____
 Email Address _____ Sex: M F Marital Status S M O
 Family Physician _____ Phone # or Name of Practice _____
 Referring Physician _____ Phone # or Name of Practice _____
 How did you hear about MEC? (*Please check one*) Insurance ____ (143) Family/Friend ____ (663) Doctor ____
 Screening ____ (120) Newspaper ____ (202) Yellow Pages ____ (60) Business/Employer ____ (150) Web Site ____ (671)
 Radio ____ (215) Television ____ (257) Mailing ____ (611) Other _____ (674) *Please describe*

Parent/Spouse/Guardian Information

Full Name _____ Social Sec # _____
 Relationship to Patient _____ Date of Birth _____ / ____ / ____
 Address _____ City _____ State _____ Zip _____
 Employer _____ Home Phone (____) _____
 In an emergency, who may we contact that does **not** live at this address?
 Name _____ Phone (____) _____ Relationship _____
Privacy laws allow only the person listed may be given medical information without patient's permission.

Health Information

Do you presently have any problems in the following areas? If "Yes", please give an explanation:

	Yes	No	Explanation
Eyes: Decreased, Blurred or Distorted Vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of Side Vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning, Itching or Dry Eyes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous Discharge or Redness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Are you being treated in any of the following areas? If "yes" please give an explanation:

	Yes	No	Explanations
Ear/Nose/Throat: Sinus congestion or allergies?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent sore throat or runny nose?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular: Heart condition/blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension/Arteriosclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory: Lungs/Breathing/Asthma?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal: Stomach/Intestines?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary: Genital/Kidneys/Bladder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: Muscle or Joint Pain?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Conditions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood or Lymph Node Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____

