

Patient Registration Form: David J. Baker, MD & Arthur W. Fleming, MD

Title	<input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Name		Social Security #	
Address		Birth Date	
City		Parent/Guardian	
State		Referred By	
Zip		Occupation	
Home Phone		Cell Phone	
Work Phone			
Employer's Name		Employer's Address	

Have you been in an auto accident? Yes No Date of Injury _____ State in which Injury Occurred _____

Have you been injured at work? Yes No Date of Injury _____ State in which Injury Occurred _____

General Health: Check Only Those Which Apply

Cataracts Macular Degeneration Diabetes Glaucoma High Blood Pressure

Other Condition(s)	
Medications are you presently taking	
Name of family doctor	
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List any allergies to medications	
Date of last exam	
Did you ever wear glasses or contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No How old are they?
Family history of eye disorders	

Please present all insurance information to receptionist

Primary Insurance		Secondary Insurance	
Insurance Name		Insurance Name	
Employer		Employer	
Insured's Name		Insured's Name	
Birth Date		Birth Date	
Insured's SS#		Insured's SS#	

Patient Authorization

I authorize the release of this medical information or other information necessary to process this claim. In addition, I authorize payment of any medical benefits to Dr. Arthur Fleming or Dr. David Baker for services provided by them either in office or hospital.

Patient/Guardian Signature: _____ Date _____

Relationship to patient (if guardian) _____