New Patient Registration Form

CES Medical - Comprehensive Eye Care

Please complete all sections of this form and bring it with you to your appointment. This information helps us provide you with the best possible care.

Personal Information

Patient Details:

- Full Name: _____
- Preferred Name: _____
- Date of Birth: _____
- Gender: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
- NHS Number: _____

Contact Information:

- Home Address:
  - Street: _____
  - City: _____
  - County: _____
  - Postcode: _____
- Phone Numbers:
  - Home: _____
  - Mobile: _____
  - Work: _____
  - Email Address: _____
  - Preferred Contact Method: ☐ Phone ☐ Email ☐ Text ☐ Post

Emergency Contact:

- Name: _____
- Relationship: _____
- Phone Number: _____
- Address (if different): _____

Referral Information

How did you hear about CES Medical?

☐ GP Referral ☐ Optometrist Referral ☐ Hospital Referral ☐ Self-Referral ☐ Friend/ Family ☐ Internet Search ☐ Insurance Provider ☐ Other: _____

Referring Healthcare Provider:

- Name: _____
- Practice/Hospital: _____
- Address: _____
- Phone: _____

Referral Details:

- Date of Referral: _____
- Reason for Referral: _____
- Urgency: ☐ Routine ☐ Urgent ☐ Emergency

Insurance and Payment Information

Payment Method:

☐ NHS Funded ☐ Private Medical Insurance ☐ Self-Pay

If Private Medical Insurance:

- Insurance Company: _____
- Policy Number: _____
- Group Number: _____
- Policy Holder Name (if different): _____
- Relationship to Patient: _____
- Authorization Number (if applicable): _____

If Self-Pay:

- Preferred Payment Method: ☐ Card ☐ Cash ☐ Bank Transfer ☐ Payment Plan

Current Eye Concerns

Primary Reason for Visit:

_____

_____

When did you first notice this problem?

_____

Symptoms (check all that apply):

☐ Blurred vision ☐ Double vision ☐ Eye pain ☐ Headaches ☐ Flashing lights ☐ Floaters ☐ Dry eyes ☐ Watery eyes ☐ Light sensitivity ☐ Night vision problems ☐ Loss of peripheral vision ☐ Difficulty reading ☐ Other: _____

Rate your current vision problems:

- Right Eye: ☐ No problems ☐ Mild ☐ Moderate ☐ Severe
- Left Eye: ☐ No problems ☐ Mild ☐ Moderate ☐ Severe

Do you currently wear glasses or contact lenses?

☐ Yes ☐ No

If yes:

- Type: ☐ Glasses ☐ Contact lenses ☐ Both
- When was your last eye test? _____
- Where was your last eye test? _____

Previous Eye History

Have you ever had eye surgery?

☐ Yes ☐ No

If yes, please provide details:

- Type of Surgery: _____
- Date: _____
- Surgeon/Hospital: _____
- Complications: ☐ None ☐ Yes (describe): _____

Previous Eye Conditions (check all that apply):

☐ Cataracts ☐ Glaucoma ☐ Diabetic retinopathy ☐ Macular degeneration

☐ Retinal detachment ☐ Eye infections ☐ Eye injuries ☐ Lazy eye

☐ Other: _____

Family History of Eye Problems:

☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Diabetic eye disease ☐ Blindness

☐ Other: _____

Consent and Data Protection

Consent for Treatment:

☐ I consent to examination and treatment by CES Medical staff

☐ I understand that no guarantee of successful treatment can be given

Data Protection and Privacy:

☐ I consent to my personal data being processed for healthcare purposes

☐ I consent to being contacted about my treatment and appointments

☐ I consent to anonymous data being used for quality improvement (optional)

Communication Preferences:

☐ I would like to receive information about CES Medical services

☐ I would like to receive eye health education materials

☐ I consent to follow-up surveys about my care experience

Patient Signature: _____

Date: _____

Parent/Guardian Signature (if patient under): _____

Date:_____

For Office Use Only:

- Registration Date: _____
- Patient ID: _____
- Registered by: _____
- Initial Assessment Date: _____