



Eyes in Disguise Optometry
Michelle C Blas, OD

Existing Patient Registration Form

Thank you for being a continuing patient here at Eyes in Disguise Optometry. Please fill out the information below so we can keep our records updated with your most current information.

Patient Information

Full Name: _____

Date of Birth: _____

Address: _____

Social Security #: _____

Home Phone #: _____

Email Address: _____

Cell Phone #: _____

Medical Doctor: _____

Last Eye Exam: _____

Emergency Contact: _____

Patient Communications: How do you prefer to receive information regarding appointments and services at Eyes in Disguise Optometry? (Circle all the apply) Email Text Phone

Patient Portal: Are you interested in participating in our online patient portal to have access to your health information at Eyes in Disguise Optometry? (Circle all that apply) Yes, tell me more No

Patient History

Are you having any visual difficulties? If yes please explain: _____

Are you taking any new medications? Or is there any new medical information we need to know?

Social History

Do you currently use tobacco products? No Yes

If yes, type/how long: _____

Do you drink alcohol? No Yes

If yes, type/amount: _____

Do you use illegal drugs No Yes

If yes, type/amount: _____

Signature: _____

Date: _____