NANTASKET EYE CARE REGISTRATION AND HISTORY

DEMOGRAPHICS

Name_____ Date_____

Address_____City_____State_____ Zip_____

Email_____ DOB_____ Sex □ M □ F

Home Phone_____ Cell _____Work_____

Preferred method of contact- ☐ Home ☐ Cell ☐ work Can we contact you via email? ☐ Yes ☐ No

Emergency Contact_____ Phone_____

Marital Status_____ Ethnicity ☐ White ☐ African American ☐ Hispanic ☐ Other_____

Employer/School_____ Occupation_____

To whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____ Relationship_____ DOB_____

Do you have vision insurance? □Y □ N If yes, □ VSP □ EyeMed □ MassHealth □ Other?_____

Primary Insurance Co. _____ Policy #_____

Secondary Insurance Co. _____ Policy#_____

ASSIGNMENT AND RELEASE OF ALL INSURANCES & AUTHORIZATION FOR MEDICARE

I certify that I, and/or my dependants have insurance coverage with _____ and Assign directly to **HILARY W. WILLIAMS, O.D.** all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefit or the benefits payable for related services. The consent will end at the end of my current treatment plan is completed or one year from the date signed below.

_____ _____ _____

Signature of Patient, Parent or Guardian Print Name Date

GENERAL HEALTH INFORMATION

Primary Care Physician _____Phone_____

Address_____

Drug Allergies_____

MEDICATIONS **Pharmacy**_____ **Phone**_____

Are you pregnant? ___ Tobacco use____ Alcohol use_____

GENERAL HEALTH CONTINUED...

***What is the main reason for your visit?**

_____

Height_____ **Please check all that apply** **Weight_____**

	YES/NO	EXPLAIN		YES/NO	EXPLAIN
High Blood Pressure			Allergies		
Diabetes			Headaches/Migraines		
Elevated Cholesterol			Head Trauma		
Heart Condition			Auto Immune		
Respiratory Illness			Cancer		
Thyroid			Hepatitis (type_____)		
Stroke			Aids/HIV		

Are there any additional health conditions you have been diagnosed with and/or treated for?

_____

EYE HEALTH HISTORY

Please check all that apply to you or your family

	Yourself	Family		Yourself	Family
Cataracts			Eye Injury Itchy/Burning		
Dry Eye			Eye Strain/Fatigue		
Glaucoma			Floaters/Spots		
Lazy Eye			Legally Blind		
Macular Degeneration			Light Sensitive		
Retinal Detachment/Disease			Loss of Vision		
Flashes of light			Poor Night Vision		
Blurred Vision			Red/Bloodshot Eyes		
Double Vision			Watery Eyes/Tearing		
Eye Infections			**Eye Surgery**_____		

Are there any additional eye conditions you have been diagnosed and/or treated for?

_____

Do you wear any eyewear? ☐ **GLASSES** - ☐ Single Vision ☐ Lined Bi-focal ☐ Progressive
☐ Prescription Sunglass ☐ Polarized ☐ Anti-reflective Coating
☐ Transitions ☐ Glass

☐ **CONTACTS -** Brand/Type_____
Any problems with your current contacts? ☐Yes ☐No
Explain_____

Wear Schedule ☐ All the time ☐ Driving ☐ Computer ☐ Reading ☐ TV ☐ Recreational
☐ Work ☐ Fine Detail Type Work

Previous Eye Doctor _____ City_____
Date of last eye exam_____