

PATIENT INFORMATION

_____ M / F _____ / ____ / ____
Last Name First Name MI Sex Date of Birth

ADDRESS:

Street

City State Zip Code

COMMUNICATION:

Preference: (please check one)
Telephone:
 (____) _____
Cell
 (____) _____
Home
 (____) _____
Work Ext.

Email Address

Primary Language

Special Needs (for example, wheelchair, ASL)

Race: (please check one)
 American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or Pacific Islander
 White
 Other

Ethnicity: (please check one)
 Unknown
 Hispanic
 Non Hispanic

Primary Care Physician Name:

Address & Phone Number:

PERSON RESPONSIBLE (Must be parent or legal guardian if patient is under 18 years of age)

Check here if person responsible is same as patient.

Last Name First Name MI Relationship to patient

ADDRESS:

Street (____) _____
Home Phone #

City (____) _____
Work Phone # Ext.

State Zip Code E-Mail Address

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Plan Name

Subscriber's Name

Policy/ID #

Subscriber's Date of Birth

Group # (if applicable)

SECONDARY INSURANCE:

Insurance Plan Name

Subscriber's Name

Policy/ID #

Subscriber's Date of Birth

Group # (if applicable)

VISION PLAN: (VSP, EyeMed, etc.)

Vision Plan Name

Subscriber's Name

Policy/ID #

Subscriber's Date of Birth

Group # (if applicable)

Please remember to always bring your insurance card(s) with you to your appointment.

**AUTHORIZATION TO DISCUSS MEDICAL
INFORMATION WITH DESIGNATED PARTIES**

Patient Name: _____ Date of Birth: _____

I authorize the doctors and staff of Massachusetts Eye Associates to discuss the medical care of the patient named above with the people listed below.

PLEASE DESIGNATE FAMILY MEMBERS AND/OR INDIVIDUALS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION:

Name	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

I understand that I can revoke this authorization at any time and that my treatment is not contingent on my signing this authorization.

Patient: _____
(print name)

Patient representative: _____
(print name)

Signature of patient or patient's representative: _____

Date: _____

Please bring your signed forms and completed health care questionnaire with you to your appointment.

Massachusetts Eye Associates Notice of Privacy Practices

I understand that the doctors and staff at Massachusetts Eye Associates are called “providers” and that if I want to receive care, I need to give them permission to share information about my health among themselves and with other individuals for evaluation, treatment, and continuity of my health care.

I understand that **Massachusetts Eye Associates has a Notice of Privacy Practices that describes in detail how my health care information is used and shared with others.** This notice explains when I need to give further approval for providers to use my health information or share it outside of the Practice, and when my permission is not needed for the providers to use it or share it outside of the Practice. I understand that I have a right to request a copy of the Notice and I have the right to read the Notice of Privacy Practices before signing this consent.

By signing below, I acknowledge that I have read and understood the Notice of Privacy Practices Policy for Massachusetts Eye Associates and consent to the uses and disclosures therein.

Patient Name (please print)

Patient/Guardian Signature

Patient Financial Agreement

The following information outlines your financial responsibility related to payment for professional services.

We participate in most major health plans. We have contracts with many HMO’s, PPO’s, insurance companies, vision plans and government agencies including Medicare and Medicaid. Our business office will submit claims for any services provided to a patient who is a member of one of these plans and will assist you in any reasonable way we can to help get your claim paid; however, this is not a guarantee of payment.

You are responsible for any charges not paid by your insurance. It is your responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as your primary insurance has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

By obtaining medical services provided by Massachusetts Eye Associates, I authorize my insurance carrier to make payments directly to Massachusetts Eye Care, P.C. for medical, diagnostic, or surgical services rendered.

Patient/Guardian Signature

Health History

Name: _____

Date: _____

Ocular History	YES	NO	Description	Family History	YES	NO	Relation
Cataracts	_____	_____	_____	Cataracts	_____	_____	_____
Glaucoma	_____	_____	_____	Glaucoma	_____	_____	_____
Retinal Disease	_____	_____	_____	Retinal Disease	_____	_____	_____
Macular Degeneration	_____	_____	_____	Macular Degeneration	_____	_____	_____
Diabetic Retinopathy	_____	_____	_____	Strabismus	_____	_____	_____
Eye Injury	_____	_____	_____	(e.g. Crossed Eyes)	_____	_____	_____
Strabismus	_____	_____	_____	Amblyopia	_____	_____	_____
(e.g. Crossed Eyes)	_____	_____	_____	(e.g. Lazy Eye)	_____	_____	_____
Amblyopia	_____	_____	_____	Blindness	_____	_____	_____
(e.g. Lazy Eye)	_____	_____	_____	Cancer	_____	_____	_____
Dry Eyes	_____	_____	_____	Heart Disease	_____	_____	_____
Glasses	_____	_____	_____	Diabetes	_____	_____	_____
Contact Lenses	_____	_____	_____	Other	_____	_____	_____
Other	_____	_____	_____				

Please list all medical conditions:

**Please list all medications you are now taking, including over the counter drugs and supplements.
Please list dosage if possible:**

Please list all medications you are allergic to: _____

Please list all surgeries you have had, including date of surgery and doctor who performed the surgery if possible:

Social History	Yes	No	If so, how much	Former Smoker
Smoking	_____	_____	_____	_____
Alcohol	_____	_____	_____	
Recreational Drugs	_____	_____	_____	
Occupation	_____			
Hobbies	_____			

Please turn the page to complete the other side →

Name: _____

Date: _____

Review of Systems Check here if all normal _____

<u>Constitutional</u>	YES	NO
Fever	_____	_____
Chills	_____	_____
Night Sweats	_____	_____
Fatigue	_____	_____
Weight Change	_____	_____
 <u>Cardiovascular</u>		
Chest Pain	_____	_____
Irregular heart rhythm	_____	_____
Irregular heart rate	_____	_____
Leg Swelling	_____	_____
Syncope (Fainting)	_____	_____
 <u>Ear, Nose & Throat (ENT)</u>		
Ear Pain	_____	_____
Hearing Loss	_____	_____
Sinus Pain	_____	_____
Sore Throat	_____	_____
Tinnitus (ringing in ears)	_____	_____
Vertigo	_____	_____
 <u>Respiratory</u>		
Cough	_____	_____
Wheezing	_____	_____
Shortness of Breath	_____	_____
Sleep Apnea	_____	_____
 <u>Gastrointestinal</u>		
Abdominal Pain	_____	_____
Change in Appetite	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____
Nausea	_____	_____
Vomiting	_____	_____
 <u>Genitourinary</u>		
Dysuria (painful urination)	_____	_____
Hematuria (blood in urine)	_____	_____
Change in urine stream	_____	_____
Urethral discharge	_____	_____
Lesion	_____	_____

<u>Musculoskeletal</u>	YES	NO
Back Pain	_____	_____
Neck Pain	_____	_____
Joint Pain	_____	_____
Muscle Pain	_____	_____
 <u>Integumentary</u>		
Bruising	_____	_____
Skin Rash	_____	_____
Skin Lesion	_____	_____
 <u>Neurological</u>		
Abnormal Balance	_____	_____
Confusion	_____	_____
Numbness	_____	_____
Weakness	_____	_____
Difficulty with Speech	_____	_____
Headache	_____	_____
 <u>Psychiatric</u>		
Anxiety	_____	_____
Depression	_____	_____
Mania	_____	_____
Suicidal Thoughts	_____	_____
Delusional	_____	_____
Hallucinations	_____	_____
 <u>Endocrine</u>		
Excessive Thirst	_____	_____
Polyuria (excessive urination)	_____	_____
Cold Intolerance	_____	_____
Heat Intolerance	_____	_____
Excessive Hunger	_____	_____
 <u>Hemato/Lymphatic</u>		
Excessive Bleeding	_____	_____
Excessive Bruising	_____	_____
 <u>Allergy</u>		
Immunocompromised	_____	_____
Recurrent Fevers	_____	_____
Recurrent Infections	_____	_____
Malaise	_____	_____