massachusetts
EYE ASSOCIATES
CHELMSFORD • LOWELL • TEWKSBURY
Clear Vision for Life™

Thank you for choosing Massachusetts Eye Associates for your care.

Please bring the completed patient registration and health history with you to your appointment. If you are unable to complete these forms in advance, plan to arrive 20 minutes early for your appointment.

Insurance: Most insurance plans cover an eye exam for a specific medical problem; however, deductibles and co-pays may apply. Some plans cover "routine" eye examinations, but not all. Please know what will be covered by your insurance and what your responsibility is. If your insurance requires you to obtain a referral before seeing a specialist, please obtain it beforehand or we will need to reschedule your exam.

Your Appointment: Bring your current insurance card(s), any medication you are taking for your eyes, your glasses or contact lenses and packaging to help your doctor identify which lens you are wearing. If you wear contacts, please bring your glasses as well and wear your contacts to your appointment. Your examination will take approximately one hour. Co-payments and fees not covered by insurance are due at the time of your visit.

Please make every effort to **arrive on time for your appointment** and call us if you are running late. If you are more than 15 minutes late we reserve the right to reschedule your appointment to a different date.

Out of respect for other patients, **a 24-hour notice is required to reschedule or cancel your appointment.** Consecutively missed appointments will result in dismissal from the practice.

As part of your eye exam, your eyes may be dilated. Many patients experience light sensitivity and have difficulty focusing near or far for 2-3 hours.

If you have any question about your appointment or need to reschedule, please call us at 978-256-5600.

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PATIENT INFORMATION

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

ADDRESS:

Street _____

City _____ State _____ Zip Code _____

Email Address _____

COMMUNICATION:

Preference: (please check one)

Telephone

☐ (_____) _____
Cell

☐ (_____) _____
Home

☐ (_____) _____
Work Ext.

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 _____

City _____

State _____ Zip Code _____

(_____) _____
Home Phone #

(_____) _____
Work Phone # Ext.

E-Mail Address _____

(complete on reverse side)

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.

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Name: _____ _____/_____/_____
Date of Birth

Date: _____

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

Family History	YES	NO	Relation
Cataracts			
Glaucoma			
Retinal Disease			
Macular Degeneration			
Strabismus (e.g. Crossed Eyes)			
Amblyopia (e.g. Lazy Eye)			
Blindness			
Cancer			
Heart Disease			
Diabetes			
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				

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REVIEW OF SYSTEMS

Name: _____ _____/_____/_____
Date of Birth

Are you currently experiencing any of the following symptoms?

Check here if all normal_____

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

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

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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.

_____
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 Associates, P.C. for medical, diagnostic, or surgical services rendered.

Patient/Guardian Signature_____

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Authorization to Discuss Medical Information with Designated Parties

Patient Name: _____ Date of Birth: _____

I authorize the physicians 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 WHO 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.

Print patient name: _____

Print patient representative's name: _____

Signature of patient or patient's representative: _____

Date: _____

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