EASTON EYE CARE and OPTICAL

Patient Registration Form
(Secure online form is located at www.eastoneyecare.net)

Please complete the information below and bring it when you come to our office.
We understand that this form contains confidential information and we will handle with due diligence to protect your privacy.

Select a Practitioner:
- Stanley A. Feinblum, O.D.
- Alan S. Bishop, O.D.

Select an Office Location:
- Cambridge Office (Dr. Bishop Only)
- Easton Office

Contact Information:

Name (as it appears on your insurance card)
_____

Address 1
_____

Address 2
_____

City State / Province
_____

Zip / Postal Code
_____

Home Phone (Messages/Reminders)
_____

Work Phone
_____

Cell Phone
_____

Other Phone
_____

Email Address
_____

Personal Information:

Gender: Female Male

Date of Birth (MM/DD/YYYY) _____

Social Security Number _____

Marital Status:
Divorced Legally Separated Married Single Widowed
Other

Employment Status:

Employed Full-Time	Employed Part-Time	Not Employed
On Active Military Duty	Retired	Self-Employed
Student Full-Time	Student Part-Time	Other

Employer

_____

Occupation

_____

How were you referred to our office?

Friend or Family	Family Doctor	Ophthalmologist	Insurance Company
Newspaper	Television	Radio	Received Mailing
Internet	Other Optometrist		Other »

Eye History:

Please check off any current conditions you suffer from:

- Headaches
- Glare/Light Sensitivity
- Tired Eyes
- Amblyopia (lazy eye)
- Burning
- Dryness
- Watery Eyes
- Eye Pain and/or Soreness
- Foreign Body Sensation
- Infection of Eye or Lid
- Itching
- Mucous Discharge
- Drooping eyelid(s)
- Redness
- Sandy or Gritty Feeling
- Strabismus (crossed eye)
- Blurred Vision at Distance
- Blurred Vision at Near
- Haloes
- Double Vision
- Floaters or Spots
- Fluctuating Vision
- Loss of Vision
- Loss of Side Vision
- Flashes of Light

I stopped wearing glasses because:

_____

I stopped wearing contact lenses because:

_____

Glasses History: (Skip if you don't wear glasses)

What glasses do you own?

Single Vision	Bifocals	Safety Glasses	Backup Glasses
Progressive	Trifocals	Sports Glasses	Sunglasses
Other			

How many hours a day do you use a computer? _____

Glasses History: (continued)

How many inches away, approximately, do you sit from your computer monitor? _____

Please check off any current conditions you suffer from:

- I am having problems with my current glasses
- There are times when I would rather not be wearing glasses
- I have problems with glare
- I have problems with night vision
- I am allergic to nickel (e.g. frames of glasses)
- I don't have spare set of glasses
- My spare glasses have an incorrect prescription
- My sunglasses are missing UV (ultra-violet) protection

Contact Lens History: (Skip if you don't wear contacts)

What brand of contact lenses do you wear?

_____

How old are your current lenses?

_____

How often do you replace or dispose your contact lenses?

_____

What brand of solution do you soak your lenses in?

_____

What is your typical wearing schedule? Hours/day Days/week

_____

Please check off any current problems with your current contact lenses:

- There are times when I would rather not be wearing contact lenses
- I am interested in changing or enhancing my eye color
- I am interested in a non-surgical method of vision correction
- I am interested in refractive laser surgery
- I don't have a spare set of contact lenses
- My spare contact lenses have an incorrect prescription

Medical History:

When, approximately, was your last eye exam? _____

Where did you get your last eye exam? _____

When, approximately, was your last physical exam? _____

Who is your primary care physician? _____

Patient Registration Form (Continued)

Medical History (continued)

Do you drink alcohol?

No Yes, 1 per day Yes, 2 - 3 per day Yes, 4+ per day

Do you smoke?

No Yes, 1/2 pack per day Yes, 1 pack per day Yes,1+ pack per day

Please list all medical conditions you have ever had (Diabetes, High blood pressure, Arthritis, etc.)

_____

_____

Please list all eye diseases you have ever had (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment)

_____

_____

Please list any medical or eye conditions that run in your family and the relationship of the family member (blood relatives)
(Diabetes, High blood pressure, Cancer, Glaucoma, Macular degeneration, etc.)

_____

_____

Please list all hospital surgeries you have ever had:

_____

Please list all prescription and over-the counter medications you take and for what conditions:

_____

Please list all drug allergies you have:

_____

Please check off any current conditions you suffer from:

Chronic fever, unexpected weight loss/gain, fatigue
Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
Heart problems (eg. Chest pain, irregular heart beat, swelling of feet, cold hands/feet)
Respiratory problems (eg. Shortness of breath, wheezing, coughing)
Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)
Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)
Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
Skin problems (eg. Rashes, excessive dryness, growths or lumps)
Neurological problems (eg. Numbness, weakness, headaches, “blackouts”)
Psychiatric problems (eg. Depression, anxiety)
Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)

Primary Insurance or Discount Plan:

Please bring all medical and/or vision insurance cards with you to your appointment.

Insurance Company or Discount Plan Name

_____

Address

_____

Insured's Name

_____

Identification Number

_____

Group Number

_____

Insured's Date of Birth

_____

Insured's Social Security Number

_____

Patient's Relation to Insured

_____

Secondary Insurance or Discount Plan: (if applicable)

Please bring all medical and/or vision insurance cards with you to your appointment.

Insurance Company or Discount Plan Name

_____

Address

_____

Insured's Name

_____

Identification Number

_____

Group Number

_____

Insured's Date of Birth

_____

Insured's Social Security Number

_____

Patient's Relation to Insured

_____

HIPAA Privacy Policy - Health Information Protection

This policy is available on our web-site (www.eastoneyecare.net) and is located in our waiting room. Please review this policy and sign the attached HIPAA Privacy Policy document. Obtaining this signed document from you is a federal regulation.

Thank-you for your time and attention. We look forward to serving you and your family with high quality service and products.