PATIENT INFORMATION FORM --- PLEASE BRING THIS COMPLETED FORM TO YOUR APPOINTMENT

BOSTON EYE PHYSICIANS AND SURGEONS, P.C.

44 Washington Street
Brookline, MA 02445 Phone (617) 232-9600 Fax (617) 232-7002

Patient Name_____ M ☐ F ☐ Date of Birth_____

Address_____

City_____ State_____ ZIP_____ SS#_____

Home Phone ( )_____ Work Phone ( )_____

Occupation_____

PERSON RESPONSIBLE FOR BILL (OTHER THAN PATIENT):

Name_____ Relationship_____

Address_____

City_____ State_____ ZIP_____

Home Phone ( )_____ Work Phone ( )_____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name_____ Relationship_____

Home Phone ( )_____ Work Phone ( )_____

NAME OF PEDIATRICIAN or PRIMARY CARE DOCTOR or REFERRING PHYSICIAN:

Dr._____

Address_____

Office Phone ( )_____

PLEASE BRING YOUR INSURANCE CARD WITH YOU AT THE TIME OF YOUR APPOINTMENT SO THAT WE MAY MAKE A PHOTOCOPY OF IT FOR YOUR MEDICAL RECORDS.

INSURANCE AUTHORIZATION

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical and surgical benefits directly to the physician or supplier of services for myself and /or dependents. I understand I am responsible for any deductibles, co-insurance, or amounts for services not covered by insurance carrier.

Signature_____ Date_____

OVER PLEASE

PATIENT MEDICAL INFORMATION SECTION

PLEASE COMPLETE THIS CONFIDENTIAL MEDICAL SURVEY. IT WILL ASSIST YOUR EYE PHYSICIAN IN YOUR MEDICAL CARE.
PLEASE RESPOND TO ALL QUESTIONS AND ADD ANY FURTHER INFORMATION YOU FEEL IS PERTINENT.

1. DO YOU OR HAVE YOU HAD:

Yes	No	Diabetes		Yes	No	Stomach disease	
Yes	No	Insulin treatment		Yes	No	Thyroid disease	
Yes	No	High Blood Pressure		Yes	No	Arthritis	
Yes	No	Heart attack		Yes	No	Gout	
Yes	No	Cardiac pacemaker		Yes	No	Liver disease	
Yes	No	Asthma		Yes	No	Bleeding disorder	
Yes	No	Emphysema		Yes	No	Blood clots	
Yes	No	Pneumonia		Yes	No	Anemia	
Yes	No	Smoking history		Yes	No	Mental disorder	
Yes	No	Cancer		Yes	No	AIDS/ARC/ + HIV test	
Yes	No	Stroke		Yes	No	Syphilis	
Yes	No	Neurologic disorder		Yes	No	Alcohol/Drug abuse	

2. HAVE YOU HAD ANY EYE DISEASES, SURGERY, OR INJURY? Yes No

Please list:_____

3. DO YOU USE ANY EYE MEDICATIONS? Yes No

List medications:_____

4. ARE THERE ANY EYE DISEASES THAT RUN IN YOUR FAMILY SUCH AS GLAUCOMA, CATARACTS, MACULAR DEGENERATION, ETC. Yes No

Please List:_____

5. HAVE YOU HAD ANY MAJOR OPERATIONS? Yes No

Please list:_____

6. DO YOU USE ANY OTHER MEDICATIONS? Yes No

List medications:_____

7. ARE YOU ALLERGIC TO ANY MEDICATIONS? Yes No

Please list substance:_____

SIGNED_____ **DATE**_____

THANK YOU

revised 6/14/2002