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