PATIENT HISTORY RECORD

Date:_____

Patient Name:_____ Date of Birth:_____

Reason for visit: Routine exam____ Problem, please explain_____

_____

Date of last eye exam:_____

Medical History: circle those that apply

Diabetes	Strabismus	Retinal disease	High blood pressure	Cataracts
Cancer	Amblyopia	Serious eye injury	Glaucoma	Prostate
Heart disease	Lupus	Dry eye Syndrome	Arthritis/Rheumatoid	Thyroid

Have you ever had eye surgery or other surgery?

No____If yes, please explain_____

_____.

Do you have any drug or food allergies? No_____If yes, please list_____

_____.

If your family member has been diagnosed with any of the following, please circle.

Diabetes Retinal disease Glaucoma

Do you smoke? No____ Former_____If yes, how much_____.
Do you drink alcohol? No_____If yes, how much?_____.

Do you wear contact lenses? No_____ Yes_____ .

If yes, which type? Soft_____ Rigid gas permeable_____Specialty_____.

*Brand*_____

There is an additional fee for contact services (fitting or update) which your insurance may not cover. You are responsible for these charges at the time of service.

SIGNATURE ON FILE

Sign below to authorize your insurance company to send payment for your services to Andover Eye Associates. I am authorizing the release of any medical information to the insurance company in order for them to process any and all claims for reimbursement on my behalf. I understand that I am financially responsible for financial charges that are not paid by my insurance.

_____ Date:_____

Signature

NOTICE OF PRIVACY PRACTICES

I have been provided with a notice of Privacy Practices and I have had the opportunity to read it.

I authorize Andover Eye Associates to release health information, not only to my doctors but also to the following individuals:

_____ _____

_____ _____

_____ _____

I understand that I may change this list at any time.

Signature_____ Date_____