NEWTONeye

REGISTRATION & MEDICAL HISTORY QUESTIONNAIRE

Medical insurance plans require completion of a complete medical history. **All information is private and confidential & will not be released to anyone except by written authorization from you or your legal guardian.**

Date: ____/____/____ Mr. Mrs. Ms. Miss Dr. Date of Birth: ____/____/____

Name:_____ Social Security #_____

Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Personal Email Address:_____ (To be used for doctor-patient communication ONLY)

Primary Care Physician: _____

Date of last complete eye examination: ____/____/____ Date of last complete medical physical: ____/____/____

Emergency contact person and telephone number: _____

Any medication allergies? [None]_____Are you pregnant? Yes No N/A

Current eye medications (including over-the-counter):
[None]_____

Current non-eye medications: [None]_____

Eye surgical procedures & dates: [None]_____

Non-eye surgical procedures & dates: [None]_____

Do you or have or have you had any of the following?
Please explain "yes" answers below, including the date of diagnosis

SELF			FAMILY		
Y	N	Eye injuries_____			
Y	N	Sudden Loss of vision_____			
Y	N	Glaucoma_____	Y	N	glaucoma
Y	N	Macular degeneration_____	Y	N	macular degeneration
Y	N	Cataracts_____	Y	N	cataracts (pre- age 50)
Y	N	Retinal detachment_____	Y	N	retinal detachment
Y	N	Diabetic eye disease_____			

Y N Amblyopia (healthy eye NOT seeing 20/20 WITH glasses, "lazy eye")_____

Y N Strabismus(an eye turning in, out, up or down)_____

Y N Any other eye diseases or disrders_____

Y N Seasonal or general allergies_____

SELF	FAMILY	
Y N	Y N	Rheumatoid arthritis, lupus, other autoimmune diseased (circle)_____
Y N	Y N	Heart disease, high blood pressure, chest pain (circle)_____
Y N	Y N	Circulation Problems, blood vessel disease_____
Y N	Y N	Breast disease_____
Y N	Y N	Recent fever or weight loss (circle)_____
Y N	Y N	Ear pain, hearing loss, nosebleeds, hoarseness (circle)_____
Y N	Y N	Thyroid condition, pituitary or other endocrine glands (circle)_____
Y N	Y N	Diabetes_____
Y N	Y N	Diseases of liver or spleen (circle)_____
Y N	Y N	Diseases/problems with reproductive organs, kidney or bladder (circle)_____
Y N	Y N	Bleeding disorders, anemia, phlebitis, other blood disease (circle)_____
Y N	Y N	Swelling or problems with lymph nodes_____
Y N	Y N	Chronic skin rashes, skin cancer or other skin problems (circle)_____
Y N	Y N	Osteoarthritis, bone, joint or muscle diseases or conditions (circle)_____
Y N	Y N	Lumps or tenderness in neck or other neck problems (circle)_____
Y N	Y N	Neurological disease, paralysis, stroke, seizures (circle)_____
Y N	Y N	Frequent headaches, mental illness, depression (circle)_____
Y N	Y N	Shortness of breath, lung disease, tuberculosis, emphysema (circle)_____
Y N	Y N	Any forms of cancer_____
Y N	Y N	Any other diseases or conditions_____

SOCIAL HISTORY: Marital Status: Single Married Divorced Widowed Partner Other

Occupation: _____ Occupation Duties: _____

Sports: _____ Hobbies: _____

Alcohol Use? No Yes Average drinks per day? _____ Tobacco Use? No Yes Average Packs a day? _____

Use of illegal drugs or use of drugs not prescribed for you? No Yes Please describes: _____

Who referred you to Newton Eye?_____

Signature_____ Date: _____/_____/_____
(Parent / Guardian, if under 18 years

Reviewed by: _____OD Date: _____/_____/_____
(DR's Signature)

NEWTONeye
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Wellesley, MA 02481
617-332-1471

WAIVER/ASSIGNMENT OF BENEFITS

I request that NEWTONeye submit claims to my insurance carrier for "covered services". I authorize NEWTONeye to receive payment directly from said insurance carrier for services rendered. I authorize this holder of medical information about me to release to HCFA any information to determine benefits payable for related services.

I understand that I am financially responsible and agree to pay for any services furnished to me by NEWTONeye that are not covered by my insurance carrier(s).

I understand that I am financially responsible and agree to pay for any services furnished to me by NEWTONeye as a result of my failure to obtain the necessary referral and/or authorization from my primary care and/or referring physician when required.

I understand that most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes. Please ask for a quote of these additional fees if desired.

I understand that if my deductible has not been met, then I am responsible for the charges incurred.

Please note: It is your responsibility to know, at the time of service, what your insurance covers. We cannot bill your insurance retroactively.

Patient Signature_____ Date:_____
(parent or guardian must sign if pt.is under 18 years of age)

Patient Name:_____ (please print)

Guarantor/Subscriber Information:
Name:_____ Phone number:_____
Address of guarantor (if different):_____

Date of Birth: _____ Social Security #:_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices.

Signature: _____ Date:_____