OFFICE USE ONLY:
Date _____

Account # ____

sacopeevalley
EYE CARE

WELCOME TO OUR OFFICE!

NAME_____ **DATE OF BIRTH**_____ **AGE**_____ **M□ F□**

ADDRESS/PHONE/E-MAIL
MAILING ADDRESS_____
TOWN_____
STATE_____ ZIP_____
E-mail: _____

(Please **CIRCLE** your preferred phone number)
HOME PHONE_____
CELL PHONE_____
WORK PHONE_____
May we contact you by e-mail (for reminders/newsletters) YES□ NO□

MARITAL STATUS: SINGLE-□ DIVORCED-□ WIDOWED-□ MARRIED-□ **SPOUSE NAME** _____
SOCIAL SECURITY NUMBER _____-_____-_____
PARENT/GUARDIAN NAME _____**Parent Date of Birth**___/___/____(FOR CHILDREN)

EMERGENCY CONTACT
NAME_____ PHONE_____ RELATIONSHIP_____
FAMILY PHYSICIAN
NAME OF DOCTOR OR OFFICE_____PHONE_____
ADDRESS _____

METHOD OF PAYMENT: CASH□ CHECK□ CREDIT/DEBIT CARD□ CARE CREDIT□
INSURANCE COMPANY (please present card) _____
EMPLOYER (Or School**)** _____ **OCCUPATION (**Or Grade**)** _____

DATE OF LAST EYE EXAM_____ **WHERE?** _____
WHAT PROBLEMS ARE YOU HAVING WITH YOUR EYES OR VISION? _____
_____
HAVE YOU HAD ANY OF THE FOLLOWING:
Cataracts-□ Double Vision-□ Drooping Eyelid-□ Dry Eyes-□ Eye Infections-□ Eye Injury-□ Eye Turn-□
Excessive Tearing-□ Flashes of Light-□ Glaucoma-□ Itchy Eyes-□ Lazy Eye-□ Prominent Eyes-□ Retinal Disease-□
HAVE YOU HAD ANY SERIOUS EYE PROBLEMS OR EYE SURGERY? NO-□ YES-□ Explain_____
_____

DO YOU WEAR GLASSES? NO-□ YES-□ **HOW OLD ARE THEY?**_____
DO YOU WEAR CONTACT LENSES? NO-□ YES-□
IF YES, WHAT TYPE: SOFT-□CONTINUOUS WEAR-□ GAS PERMEABLE-□ OTHER_____
How old are your present contact lenses? _____ Brand of current lenses? _____
Are they comfortable? YES-□ NO-□
IF NO, ARE YOU INTERESTED IN WEARING CONTACT LENSES? YES-□ NO-□

****CONTINUED ON NEXT PAGE****

REVIEW OF SYSTEMS

PLEASE MARK ONLY THOSE THAT APPLY TO **YOU**: Check here if None apply [ ]

[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Bronchitis
[ ] Cancer: Type_____
[ ] Chest Pain (angina)
[ ] Colitis/Diverticulitis
[ ] Congestive Heart Failure
[ ] Depression
[ ] Diabetes
[ ] Eczema
[ ] Elevated Cholesterol
[ ] Emphysema
[ ] Enlarged Prostate
[ ] Frequent Cough
[ ] Frequent Heartburn
[ ] Hard of hearing
[ ] Hay Fever
[ ] Heart Attack
[ ] Heart Disease
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Irregular Heartbeat
[ ] Kidney Disease (dialysis?)
[ ] Migraine (or other severe headache)
[ ] Multiple Sclerosis
[ ] Muscular Dystrophy
[ ] Nose or Throat Problems
[ ] Parkinson's Disease
[ ] Psychiatric Illness
[ ] Shortness of breath
[ ] Sinusitis
[ ] Skin Disorders
[ ] Stroke
[ ] Thyroid Disease
[ ] Tuberculosis
[ ] Ulcer
[ ] Unexplained Fever
[ ] Weakness of an extremity
[ ] Weight gain or loss

Any other medical problems not listed above? Exp1ain_____

WOMEN: ARE YOU PREGNANT OR NURSING? NO-□ YES-□

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Check here for NONE [ ]

_____

_____

ALLERGIC TO ANY MEDICATIONS? NO-□ YES-□Explain_____

_____

IS THERE A FAMILY HISTORY OF?

[ ] Diabetes [ ] Heart Disease [ ] High Blood Pressure [ ] Cancer [ ] Arthritis [ ] Thyroid
[ ] Cataracts [ ] Glaucoma [ ] Macular Degeneration [ ] Retinal Detachment

SOCIAL HISTORY

HAVE YOU EVER SMOKED? NO□ YES□ How much CURRENTLY_____ OR When did you quit? _____
DO YOU DRINK ALCOHOL? NO□ YES□ (rarely□ occasionally□ frequently□)
DO YOU USE ANY RECREATIONAL DRUGS? NO□ YES□ Type _____
HOBBIES/SPORTS/SPECIAL INTERESTS _____
ON AVERAGE, HOW MANY HOURS PER DAY DO YOU SPEND ON COMPUTERS, TABLETS, AND OR CELLPHONES? ___ HRS

HOW DID YOU HEAR ABOUT US?

Shopper's Guide□ Bridgton News□ Smart Shopper□ Insurance□ Saw Sign□ Google□ Facebook□
Please tell us who referred you so we can thank them: _____

The mission of Sacopee Valley Eye Care is to improve the quality of life of our patients by providing efficient and personal service, education about eye health, and products of the highest quality in a friendly and comfortable environment

Visit our website at www.sveyecare.com

Sacopee Valley Eye Care
91 Maple St.
Cornish, ME 04020
207-625-3700

We are required by the Health Insurance Portability and Accountability Act (HIPAA), to provide you with a copy of our Notice of Privacy Practices.

The law requires you to sign a form that acknowledges your receipt of our Notice of Privacy Practices. The Notice of Privacy Practices describes in detail which health care information, such as diagnosis and medications, we may release or discuss with other providers, insurance companies, pharmacies, etc.

We feel that most of what we have outlined in our Notice of Privacy Practices represents what exchange of information is reasonably needed to provide good care for you.

Please read the following statement and sign below:
I hereby acknowledge that I have received a copy of Sacopee Valley Eye Care's Notice of Privacy Practices and agree to its terms.

Signature _____ Date_____

Patient Name: _____ Date of Birth_____

Parent/Guardian Name (for minor children): _____

If you have insurance and would like us to submit a claim on your behalf you must review the statements and sign below. A CMS 1500 claim form can be provided for your review.
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to myself or the party who accepts assignment. I also authorize payment of medical benefits to the undersigned physician or supplier for services described on the CMS1500 claim form.

Signed_____ Date_____