PATIENT REGISTRATION

COCHECO EYE CARE
C. Andrew Frangos, OD

15 Portland Avenue, Dover NH 03820
603-742-7371

Date _____ **Name**_____
Last Name **First** **Middle Initial**

Sex ☐ **Male** ☐ **Female** **Age** _____ **Date of Birth** _____ **Last 4 SSN** _____

Address_____ **City** _____ **State**_____ **Zip**_____

Home Phone (_____**)**_____**Cell Phone (**_____**)**_____**Permission to send text reminders** ☐ **Yes** ☐ **No**

Email_____**Permission to send email reminders** ☐ **Yes** ☐ **No**

☐ **Married** ☐ **Widowed** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Minor** ☐ **Partnered for** _____ **Years**

Employer/School_____ **Occupation**_____

Employer/School Address _____ **Employer/School Phone (**_____**)**_____

In case of emergency, who should be notified?

Name_____ **Relationship**_____ **Phone (**_____**)**_____

Whom may we thank for referring you? _____

Insurance Information	
Insurance Company:	Insurance ID#:
Secondary Insurance Company:	Insurance ID#:
Guarantor's Information (if not the patient)	
Patient's Relationship to Guarantor:	
Name:	Date of Birth:
Address:	

Release

I certify that I, and or my dependent(s), have insurance coverage with the above Insurance Company(ies) and assign directly to Cocheco Eye Care, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. Initials _____

I understand that I am financially responsible for all charges not paid by insurance. Initials _____

I understand that there is a billing fee of $5.00 added on to any outstanding bill not paid within 30 days. Initials _____

I authorize the use of my signature on all insurance submissions. Cocheco Eye Care, PLLC may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Initials _____

Authorization for Release of Identifying Health Information	
The staff has permission to: (Check all that apply)	The staff has my permission to talk with: (Provide name & phone)
☐ Leave a voicemail at home	☐ Spouse/Significant Other _____
☐ Leave a voicemail on my cell	☐ Children _____
☐ Other: _____	☐ Parent _____
The staff has permission to email/fax the following when verbally or otherwise requested:	
☐ Invoices ☐ Itemized Receipts ☐ Prescriptions	

MEDICATIONS / ALLERGIES

List Medications/Vitamins you are currently taking:

_____
_____
_____
_____
_____

List allergies to medications or substances _____
_____

HEALTH HABITS

Check (✓) which you use and how much:

- ☐ **Caffeine** _____
- ☐ **Street Drugs** _____
- ☐ **Tobacco** _____

Check (✓) if your work exposes you to:

- ☐ **Stress**
- ☐ **Heavy Lifting**
- ☐ **Hazardous Substances**

Pharmacy _____ **Phone** _____

Name of Primary Care Physician _____

Medical Group Name and City/State _____

EYE HEALTH HISTORY

Previous Optometrist _____

Date of last eye exam _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving

Do you wear contacts? ☐ Yes ☐ No

Type _____

Hours per Day _____

Describe any problems with your contact lenses _____
_____

Check (✓) symptoms you currently have or have had in the past year:

☐ Blurred Vision - Distance	☐ Dizzy Spells	☐ Glaucoma	☐ Red Eyes	☐ Other: _____
☐ Blurred Vision - Near	☐ Double Vision	☐ Itchy Eyes	☐ Seeing Halos	_____
☐ Burning Eyes	☐ Dry Eyes	☐ Light Sensitivity	☐ Seeing Flashes	_____
☐ Cataracts	☐ Eye Infection	☐ Loss of Vision	☐ Twitching Eyelid	_____
☐ Color Vision	☐ Eye Injury	☐ Migraine Headaches	☐ Vision Poor	_____
☐ Crossed Eyes	☐ Eye Strain	☐ Night Vision, Poor	☐ Temporary Loss of Vision	_____
☐ Discharge from Eyes	☐ Floaters or Spots	☐ Fainting Spells, Blackouts	☐ Watering Eyes	_____

MEDICAL HISTORY

Check (✓) symptoms you currently have or have had:

GASTROINTESTINAL	CARDIOVASCULAR	EAR/NOSE/THROAT	SKIN	WOMEN ONLY:
☐ Indigestion	☐ Chest Pain	☐ Earache/Ear Discharge	☐ Hives	Pregnant ☐ Yes ☐ No
☐ Nausea	☐ High/Low Blood Pressure	☐ Hay Fever	☐ Itching/Rash	
☐ Stomach Pain	☐ Irregular/Rapid Heart Beat	☐ Loss of Hearing	☐ Change in Moles	# of Children: _____
☐ Vomiting	☐ Poor Circulation	☐ Ringing in Ears		
☐ Vomiting Blood		☐ Sinus Problems		

GENERAL			
☐ AIDS	☐ Dizziness/Fainting	☐ Liver Disease	☐ Prostate Problem
☐ Anemia	☐ Emphysema	☐ Loss of sleep	☐ Rheumatic Fever
☐ Arthritis	☐ Epilepsy	☐ Loss of weight	☐ Rheumatoid Arthritis
☐ Asthma	☐ Fever	☐ Lupus	☐ Rosacea
☐ Bleeding Disorders	☐ Forgetfulness	☐ Lyme Disease	☐ Scarlet Fever
☐ Breast Lump	☐ Gout	☐ Measles	☐ Sleep Apnea
☐ Cancer	☐ Headaches	☐ Migraine Headaches	☐ Stroke
☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ Temporal Arteritis
☐ Chicken Pox	☐ Hepatitis	☐ Mumps	☐ Thyroid Problems
☐ COPD	☐ Herpes	☐ Numbness	☐ Tuberculosis
☐ Depression/Nervousness	☐ High Cholesterol	☐ Pacemaker	☐ Ulcers
☐ Diabetes	☐ HIV Positive	☐ Pneumonia	☐ Venereal Disease
	☐ Kidney Disease	☐ Polio	☐ Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor's office if I, or my minor child, ever have a change in address, phone, insurance or health.

_____ _____

Print name of Patient, Parent, Guardian **Relationship to Patient**

_____ _____

Signature **Date**

I acknowledge that I have seen a copy of the Privacy Practices and know I can receive a copy if requested.

_____ _____

Signature **Date**