

ACCT# _____

MIDDLESEX EYE PHYSICIANS, P.C.

400 Saybrook Road, Ste. 100
Middletown, CT 06457
(860) 347-7466
Fax (860) 347-2619

4 Grove Beach Road North, Ste. B
Westbrook, CT 06498
(860) 669-5305
Fax (860) 669-9284

PATIENT INFORMATION

Patient's Name: _____ Age: _____ Date: _____
(Please Print)

Referring Physician _____
(include address/telephone#)

OCULAR HISTORY

DO YOU WEAR GLASSES: Y N CONTACT LENSES: Y N Are you interested in contact lenses? Y N

Have you ever considered Laser Vision Correction (LASIK)? Y N

What is the reason for this office visit? _____

Last Eye Physician: _____ Date of Last Eye Exam: _____

Eye Medications

Other: _____

Patient Eye History

Cataract Y N
Macular Degeneration Y N
Glaucoma Y N
Retinal Detachment Y N
Eye Surgery Y N
Other: _____

Family Eye History

Cataract Y N
Macular Degeneration Y N
Glaucoma Y N
Retinal Detachment Y N
Eye Surgery Y N
Other: _____

MEDICAL HISTORY

Primary Care Physician: _____ Date of Last Check Up: _____

Medications

(prescribed and herbal)

Other: _____

Patient Medical History

Diabetes Y N
Heart Disease Y N
High Blood Pressure Y N
Lung Disease Y N
Thyroid Disease Y N
Blood Disorders Y N
Arthritis Y N
Other: _____

Family Medical History

Diabetes Y N
Heart Disease Y N
High Blood Pressure Y N
Lung Disease Y N
Thyroid Disease Y N
Blood Disorders Y N
Arthritis Y N
Other: _____

Surgeries: _____

Allergies: _____

SOCIAL HISTORY

Smoke none / 01-ppd / 1+ppd Alcohol none / soc / 2-3xwk / daily
Weight gain / no change / loss Exercise none / occasional / weekly / daily
Recreational Drugs none / occasional / weekly / daily

Patient Signature/Guarantor _____ Date: _____

(other side)

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Patient's Name: _____ ACCT#: _____
 Marital Status: _____ Patient's SS#: _____ DOB: _____ Email Address: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____

Guardian Name: _____	Relationship: _____
Home Phone: _____	Cell Phone: _____
Emergency Contact: _____	Home Phone: _____ Cell Phone: _____
Patient's Employer	
Employer Name: _____	
Employer's Address: _____	
Is this a Work Related Injury? _____ (Y/N)	Contact Name and Phone: _____
Insurance Company Name: _____	
Address: _____	
ID No.: _____	Group No.: _____
Subscriber Name: _____	Relationship to Patient: _____
Social Security No.: _____	Date of Birth: _____
Secondary Company Name: _____	
Address: _____	
ID No.: _____	Group No.: _____
Subscriber Name: _____	Relationship to Patient: _____
Social Security No.: _____	Date of Birth: _____

AUTHORIZATION TO TREAT THE ADULT PATIENT: I hereby consent to health care for the patient named above which may include diagnostic procedures and such medical treatment as the physician considers necessary. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning treatment or examinations. I understand that it is customary, except in the case of emergency or extraordinary circumstances, that no substantial procedures are performed upon a patient until the patient (or guardian) has had an opportunity to discuss them with the physician or other health professional to the patient's (or guardian) satisfaction. A patient (or guardian) has the right to consent or refuse to any proposed procedure or treatment. No patient will be involved in any research or experimental procedure without the full knowledge and consent of that patient (or guardian).

PATIENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO THE PATIENT (If applicable): _____

RELEASE OF INFORMATION: _____ **&** **ASSIGNMENT OF BENEFITS:** _____
 I authorize Middlesex Eye to release any pertinent medical information to the appropriate insurance carrier on my behalf. If signed above, I authorize direct payment of benefits on my behalf to Middlesex Eye Physicians.

SUBSCRIBER'S SIGNATURE: _____ **DATE:** _____

MEDICARE AUTHORIZATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Middlesex Eye Physicians. I authorize Middlesex Eye Physicians to release to CMS and its agents any information needed to determine those benefits or benefits for related services.

PATIENT'S SIGNATURE: _____ **DATE:** _____