NORTH COUNTRY EYE ASSOCIATES **PATIENT REGISTRATION**
REFERRED BY PHYSICIAN OR PERSON_____

Patient's Last Name | First Name | M.I. | DOB (/ /) | SS# (/ /)

Mailing Address | City | State | Zip | Email

Home Phone | Cell Phone | Work Phone | Male or Female

Spouse's Name | Spouse's Employer | Employer's Phone Number | Cell Phone

Mother's Name (if minor) | Mother's Employer | Employer's Phone Number | Cell Phone

Father's Name (if minor) | Father's Employer | Employer's Phone Number | Cell Phone

INSURANCE

Primary Insurance Co | Subscriber Name | Subscriber Address (if different)

Identification Number | Subscriber DOB (/ /) | Subscriber SS# (/ /)

Secondary Insurance Co | Subscriber Name | Subscriber Address (if different)

Identification Number | Subscriber DOB (/ /) | Subscriber SS# (/ /)

Nearest Local Relative or Friend (not living with you)

Name | Address | City | State | Zip | Phone # | Cell #

I authorize the release of any medical information necessary to process Medicare or insurance claims and authorize payment directly to North Country Eye Associates.

_____ _____

Signature Date

NAME:_____ DATE:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. HAVE YOU EVER BEEN TREATED FOR ANY MEDICAL CONDITIONS (E.G. DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, ETC.)
   YES_____ NO_____ IF YES, PLEASE EXPLAIN_____
   _____

2. HAVE YOU EVER HAD ANY EYE DISEASE (E.G. GLAUCOMA, CATARACT, WANDERING OR "LAZY" EYE, RETINAL DETACHMENT)
   YES_____ NO_____ IF YES, PLEASE EXPLAIN_____
   _____

3. HAVE YOU EVER HAD SURGERY?
   YES_____ NO_____ IF YES, PLEASE PROVIDE DATE AND REASON_____
   _____

4. HAVE YOU EVER BEEN HOSPITALIZED?
   YES_____ NO_____ IF YES, PLEASE PROVIDE DATE AND REASON_____
   _____

5. DO YOU TAKE ANY MEDICATIONS?
   YES_____ NO_____ IF YES, PLEASE LIST_____
   _____

6. DO YOU TAKE ANY EYE MEDICATIONS?
   YES_____ NO_____ IF YES, PLEASE LIST_____
   _____

7. DO YOU HAVE DRUG OR FOOD ALLERGIES?
   YES_____ NO_____ IF YES, PLEASE LIST_____

REVIEW OF SYSTEMS:

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS: IF YES, PLEASE EXPLAIN

8. CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE?
   YES_____ NO_____ _____

9. EAR/NOSE/THROAT PROBLEMS (E.G. HEARING LOSS, SINUS PROBLEMS, SORE THROAT)
   YES_____ NO_____ _____

10. HEART PROBLEMS (E.G. CHEST PAIN, IRREGULAR HEART BEAT)
    YES_____ NO_____ _____

11. RESPIRATORY PROBLEMS (E.G. WHEEZING, COUGHING, SHORTNESS OF BREATH) YES_____ NO_____ _____

12. GASTROINTESTINAL PROBLEMS (E.G. HEARTBURN, ABDOMINAL PAIN, DIARRHEA, VOMITING) YES_____ NO_____ _____
    _____

13. URINARY PROBLEMS (E.G. PAIN OR DISCOMFORT, BLOOD IN URINE)
    YES_____ NO_____ _____

14. SKIN PROBLEMS (E.G. RASHES, EXCESSIVE DRYNESS)
    YES_____ NO _____ _____

15. MUSCULOSKELETAL PROBLEMS (E.G. MUSCLE ACHES, JOINT PAINT, SWOLLEN JOINTS) YES_____ NO_____ _____

16. NEUROLOGICAL PROBLEMS (E.G. NUMBNESS, WEAKNESS, HEADACHES, PARALYSIS) YES_____ NO_____ _____

17. PSYCHIATRIC PROBLEMS (E.G. DEPRESSION, ANXIETY)
    YES_____ NO_____ _____

FAMILY AND SOCIAL HISTORY

DO ANY MEDICAL OR EYE DISEASE RUN IN YOUR FAMILY (E.G. DIABETES, HIGH BLOOD PRESSURE, CANCER, GLAUCOMA, MACULAR DEGENERATION)
YES_____ NO_____ _____

DO YOU SMOKE? IF YES, HOW MUCH_____

DO YOU DRINK? IF YES, HOW MUCH_____

IF EMPLOYED, HOW MANY HOURS PER WEEK DO YOU WORK?_____

COMMENTS:_____
_____

M.D. SIGNATURE_____ DATE_____