QUABBIN VALLEY EYE CARE

WELCOME TO QUABBIN VALLEY EYE CARE Today's Date:_____

Patient Name: _____ Date of Birth:_____
Address: _____ Medical Insurance: _____
City: _____ State: _____Zip: _____ Vision Insurance: _____
Preferred Phone# (C): _____(H): _____ E-Mail: _____
Occupation: _____
Emergency Contact/Phone#: _____
Physician/PCP Phone #: _____
How did you hear about our office? _____

HEALTH QUESTIONNAIRE (ROS) Please Circle YES or NO Last Physical: _____
Do you have/have been diagnosed with any of the following conditions:

Allergies	Y/N	Depression/Anxiety	Y/N	Heart Disease	Y/N
Cancer	Y/N	Migraines	Y/N	High Blood Pressure	Y/N
Diabetes	Y/N	Arthritis	Y/N	Stroke	Y/N
Thyroid (Hyper/Hypo)	Y/N	Asthma	Y/N	High Cholesterol	Y/N

Other: _____

CURRENT MEDICATIONS:	ALLERGIES TO MEDICATIONS:

FAMILY HISTORY **Please Circle YES or NO**

Glaucoma	Y/N	Macular Degeneration	Y/N	Retinal Detachment	Y/N	Cataract	Y/N
High Blood Pressure	Y/N	Diabetes	Y/N	Thyroid Disease	Y/N	Lupus	Y/N
Blindness	Y/N	Other: _____					

YOUR EYE HISTORY **Please Circle YES or NO** Date of Last Exam: _____
Have you had/do you have:

Cataracts	Y/N	Glaucoma	Y/N	Retinal Disease	Y/N	Macular Degeneration	Y/N
Amblyopia	Y/N	Eye/Head Injury	Y/N	Surgery	Y/N	Flashes/Floaters	Y/N

Other: _____

YOUR SOCIAL HISTORY
Do you Smoke Y/N Drink Y/N

Wear glasses? Y/N Wear contact lenses? Y/N If Yes, What brand? _____

By signing below, I authorize any necessary medical treatment by Dr Carlos and further authorize to file a claim to my insurance(s) providing I have coverage for services rendered. I understand that I am responsible for my bill and any collection fees made necessary to collect payment of services and/or products provided if I do not have the required coverage, or the insurance claim is denied. I authorize payment from my insurance carrier directly to this provider with the understanding that all monies will be credited to my account of receipt. I also authorize any release of medical information that may be required for the determination of benefits and remittance of payment. Also, I understand I am responsible for obtaining any necessary referrals.

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

My signature below will verify that I am being offered a copy of the Notice of Privacy Policy (HIPAA*) stating my privacy rights and how they are handled at this office.

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____

We are required to request the following information – Answering is Optional

Preferred Language	Race	Ethnicity
_English	_American Indian/Alaskan Native	_Hispanic/Latino
_Portuguese	_Asian	_Native Hawaiian
_Spanish	_Black/African American	_Not Hispanic or Latino
_Other	_ Hispanic	
	_White	

Communication Preferences (Please Select All That Apply)

_Mail	_Telephone	_Email	_Text

*HIPPA Privacy Policy available upon request