Associated Eye Surgeons

Patient Name:_____ Pharmacy:_____

Patient's Primary Care Doctor:_____ Phone #:_____

Allergies :_____

List all medication(s) patient is taking including eye medications, prescriptions, over the counter medications and herbals.

Drug Name	Strength	Taken for what purpose

SOCIAL HISTORY:

1. What is your occupation?_____
2. Do you smoke? ☐ Yes ☐ Never ☐ Former Smoker
3. How much alcohol do you drink per week?_____

Associated Eye Surgeons

Plymouth - 508-747-4748 • Sandwich - 508-888-8873

Patient Information
REQUEST

Your appointment is scheduled for _____, at _____

with **Dr. Henry J. Kriegstein, MD / Lois M. Townshend, MD / Kristin S. Kenny, OD / Rachel L. Bates, OD**
Dr. Lauren Bierman, MD at Plymouth / Sandwich Office

NAME (Miss, Mrs., Ms., Mr.) _____ Date of Birth ___/___/___

ADDRESS (Street) _____ P.O. Box _____

(Town) _____ (State) _____ (Zip) _____

Telephone # (w/area code) _____ Cell phone # (w/area code) _____

Email Address _____

Emergency Contact Person _____ Telephone # (w/area code) _____

Employer Name _____

Employer Address _____

Employer Tel. # (w/ area code) _____

INSURANCE INFORMATION:

Patient Social Security # _____

Health Insurance Co. _____ Policy # _____

Subscriber Name _____ Date of Birth ___/___/___

Subscriber Relationship to Patient _____

PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT UNLESS WE ARE BILLING YOUR INSURANCE COMPANY. IF YOUR PLAN HAS COPAYMENT, THEN COPAYMENT IS DUE AT TIME OF VISIT.
We will gladly bill your insurance company. However, it is impossible for us to know in advance whether your visit will be covered. Please check your policy as you are responsible for copayments and non-covered services at the time of service.

How were you referred to our practice? ☐ Doctor (Name) _____

☐ Friend _____ ☐ Family _____ ☐ Internet ☐ Other

I authorize the release of any medical or other information necessary to process health claims to Associated Eye Surgeons. I authorize payment of benefits to Associated Eye Surgeons.

Patient Signature _____ **Date** _____

Parent Signature _____ **Date** _____
(If patient is a minor)

Thank you. Please bring any insurance documentation along with this form to your next scheduled appointment.

EYE HISTORY:

1. What is your chief reason for seeking an eye examination at this time? _____
2. Have you had previous eye surgery or any serious eye problems? _____
3. Do you have any family history of glaucoma, cataracts, diabetes, retina problems or blindness? (List relationship)

_____

4. List any serious illness or major operations with dates: _____

_____

(TURN OVER - COMPLETE)