



**ASSOCIATED EYE SURGEONS**  
**(781)749-1020 (508)747-4748 (508)888-8873**

Your appointment is scheduled for \_\_\_\_\_, \_\_\_\_\_, at \_\_\_\_\_  
with Henry J. Kriegstein, MD/Lois M. Townshend, MD/Kristin S. Kenney, OD/Kayla B. Baker, OD  
at Hingham/Plymouth/Sandwich Office.

**PLEASE HELP US BEGIN CARING FOR YOUR EYES BY PROVIDING THE FOLLOWING INFORMATION:**

**PATIENT INFORMATION:**

NAME (Miss, Mrs., Ms., Mr.) \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
ADDRESS (Street) \_\_\_\_\_ Post Office Box \_\_\_\_\_  
(Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_  
Telephone # with Area Code \_\_\_\_\_ Patient's Social Security # \_\_\_\_\_  
Emergency Contact Person \_\_\_\_\_ Telephone # \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Telephone # with Area Code \_\_\_\_\_  
Patient's Primary Care Physician \_\_\_\_\_ Pharmacy \_\_\_\_\_  
Address of Primary Care Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

**INSURANCE INFORMATION:**

Name of Health Insurance Company \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Member Number \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber Social Security Number \_\_\_\_\_  
Subscriber Relationship to Patient \_\_\_\_\_

**PAYMENT IS EXPECTED AT THE TIME OF YOUR VISIT UNLESS WE ARE BILLING YOUR INSURANCE CO. IF YOUR PLAN HAS A COPAYMENT, THEN YOUR COPAYMENT IS DUE AT THE TIME OF YOUR 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) \_\_\_\_\_

- Yellow Pages  Patient(Name) \_\_\_\_\_  Friend/Relative  Newspaper  
 Registry of M.V.  Other \_\_\_\_\_  Cape Cod Times  
 Old Colony

**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. List any eye medications and frequency of use. **(Please bring these with you)** \_\_\_\_\_  
\_\_\_\_\_
4. Do you have any family history of glaucoma, cataracts, diabetes, retina problems or blindness?(List relationship) \_\_\_\_\_  
\_\_\_\_\_

**GENERAL HEALTH:**

1. List any serious illness or major operation with dates: \_\_\_\_\_  
\_\_\_\_\_
2. List any medications that you are currently taking **(Please bring these with you)** \_\_\_\_\_  
\_\_\_\_\_
3. Do you have any allergies to drugs, foods, pollens, etc? If yes, please specify. \_\_\_\_\_  
\_\_\_\_\_

(over)



## REVIEW OF SYSTEMS

### DO YOU HAVE:

YES NO

- Decreased vision
- Blind spots in vision
- Poor side vision
- Poor night vision
- Poor color vision
- Poor depth perception
- Double vision
- Abnormal sensitivity to light
- Halos around lights
- Problems with glare
- Red eye
- Floater / light flashes
- Puffy eyes
- Eye discomfort
- Eye dryness
- Eye itching
- Pressure in or behind eye
- Tearing of eyes
- Crusting or red eyelids
- Change in blinking

### HAVE YOU HAD:

YES NO

- Blurred vision spells
  - Decreased vision spells
  - Fluctuating vision
  - Floaters in your vision
  - Flashing lights
  - Jagged lines in vision
  - Eye injury
  - Serious eye infection
  - Spasm of eye lids
  - Abnormality of eye lids
  - Lazy eye lid
  - Abnormal pupil
  - Cornea disease
  - Glaucoma
  - Cataract
  - Retinal disorder
  - Eye tumor
  - In or out turning of eye
- 
- Diabetes
  - High blood pressure
  - Heart disease
  - Lung disease
  - Neurologic disease
  - Thyroid disease
  - Hepatitis
  - HIV Positive

## SOCIAL HISTORY:

What is (was, if retired) your occupation? \_\_\_\_\_

Does your level of vision adversely affect your work/hobbies? \_\_\_\_\_

Do you smoke now? If so, how many packs per day? \_\_\_\_\_

How much alcohol do you drink per week? \_\_\_\_\_

**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.*