



Harvard Square Eye Care, P.C.

Exams • Eye Glasses • Contact Lenses

Patient Registration Form

Date: ____/____/____

Full Name: _____
First Last

Male Female → How should we address you? He/Him She/Her
Per Insurance Enrollment Preferred Name / Other: _____

Address: _____

Last Eye Exam: ____/____/____
Month Year

▪ Mobil Phone: _____

City: _____ State: _____ Zip: _____

▪ Secondary Phone: _____

▪ Email: _____ ▪ Preferred communication: Phone Email Text Mail

Birth Date: ____/____/____ Social Sec N^o Last 4: XXX-XX-____ Occupation: _____

Vision Insurance: _____ Carrier and member ID Primary Care Dr: _____ Name

Medical Insurance: _____ Carrier and member ID Address / City

Student Status: Not a student Full-time Student Part-time Student
Employment Status: Full-time Part-time Unemployed Self-employed Retired Military
How did you find us? Google Facebook Insurance directory Friend / family Walk By

Are you the primary insurance subscriber? Yes No (If not, please complete all items in this section)

Primary Subscribers Full Name: _____ Patient Relationship: _____
First Last

Address: Same as above _____ Birth Date: ____/____/____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Provider: _____ ID N^o: _____ Social Sec N^o Last 4: XXX-XX-____

Emergency Contact: Same as Primary subscriber _____ Phone: _____

Existing Conditions - Please select all that apply

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Age related macular degeneration (ARMD) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blood pressure - borderline |
| <input type="checkbox"/> Abnormal pupil | <input type="checkbox"/> Diabetic retinopathy | <input type="checkbox"/> High / Hyper cholesterol | |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Borderline blood sugar | <input type="checkbox"/> Hypertension / high blood pressure | <input type="checkbox"/> None |
| | <input type="checkbox"/> Borderline eye pressure | | |

Ocular History - Please select all that apply

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Excessive watering | <input type="checkbox"/> Loss of central vision | <input type="checkbox"/> Far sightedness (unable to see near) |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Eye pain or soreness | <input type="checkbox"/> Loss of side vision | |
| <input type="checkbox"/> Chronic Lid Infection | <input type="checkbox"/> Flashes/floating spots | <input type="checkbox"/> Mucous discharge | |
| <input type="checkbox"/> Crusting on eyelashes | <input type="checkbox"/> Foreign body sensation | <input type="checkbox"/> Redness | <input type="checkbox"/> Near sightedness (unable to see far) |
| <input type="checkbox"/> Distorted vision/halos | <input type="checkbox"/> Glare/light sensitivity | <input type="checkbox"/> Sandy or gritty feeling | |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Issues with contacts | <input type="checkbox"/> Swelling | |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Itching | | |

Please indicate any of these that you have been told you have by any other doctor, or feel that you are at risk developing.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Arcus | <input type="checkbox"/> Crossed eyes | <input type="checkbox"/> Lazy eye | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Dry eye | <input type="checkbox"/> Nearsightedness | <input type="checkbox"/> Retinitis pigmentosa |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Farsightedness | <input type="checkbox"/> Night blindness | |
| <input type="checkbox"/> Choroidal melanoma | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Presbyopia | |

Medical History - The signs and symptoms of many diseases and disorders can be detected during your routine eye examination today and effect our findings. Please select any of the following conditions that you now have or have been treated for in the past.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dry mouth / throat | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney/bladder disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Brain tumor | <input type="checkbox"/> Fever | <input type="checkbox"/> Lupus | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Other |



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Please list all medications you are currently using: _____

Do you have any allergies to medications? Yes No If yes, please list and explain: _____

List all major injuries and surgeries you have had in the last 10 years: _____

What is your general health? _____

- Yes No I am pregnant and/or nursing
 - Yes No I am diabetic
 - Yes No I have had an eye operation
 - Yes No I have had an eye injury
 - Yes No I currently wear eye glasses
 - Yes No I currently wear contact lenses
 - I don't currently wear contact lenses but I am interested in wearing them
 - I wear contact lenses for full time usage instead of bifocals, or for improved sports performance
 - Yes No I have had eye surgery to eliminate/reduce the need for eyeglasses
 - Yes No I have done eye exercises to reduce eye strain, headaches or to improve my sports performance
 - Yes No I have question(s) for the doctor _____
- Last physical exam: Date ____/____/____
 ↳ Diagnosis: _____
 Date ____/____/____
 Date ____/____/____ Injury: _____
 Correct for: Distance Reading Distance and reading
 Type: _____

Family & Social

Do any blood relatives have any of the following eye or medical conditions?

- Blindness
- Cancer
- Cataracts
- Crossed eyes
- Diabetes
- Glaucoma
- High blood pressure
- Lazy eye
- Macular degeneration
- Retinal detachment
- Retinal disease
- Thyroid disease
- Yes No I drive an automobile/motorcycle
- Yes No I consume alcohol
- Yes No I use tobacco products
- Marital Status: Single Married Widowed
- Social Status: Living alone Living with family or friends

Office Policy – Please read

Payment policy: Payment for Doctor's fees and insurance co-payments are due at the time services are rendered. Balances on eyeglasses and lens materials must be paid in full at the time of dispensing. Our office shall provide insurance billing unless other arrangements have been made. We can only confirm insurance benefits. This is NOT the same as eligibility. In some cases your medical services may not be covered by your insurance company for a given date of service. **It is the patient's responsibility for knowledge of insurance coverage and eligibility.** If insurance coverage is denied **for any reason** payment will be the responsibility of the patient. You are responsible for keeping Harvard Square Eye Care, P.C informed of any address or telephone changes. Should it become necessary to place your account with an outside collection agency due to lack of payment, you agree to pay all reasonable collection fees and related costs.

No cash refunds: Due to the nature of eyewear, we regret there can be no cash refunds. Should a problem arise, such as an incorrect eyeglass or contact lens prescription done at our office we will re-fabricate or re-order the correct lenses to meet the required prescription as prescribed by the Doctor.

We are not responsible for frame or lens breakage: Although we take every precaution to prevent breakage it does occasionally occur. We are sorry, but we can not be responsible for frames or lenses that are damaged while adjusting, fabricating new lenses or during shipping. However, we will replace the frame or lenses that are purchased with Harvard Square Eye Care, P.C. while under warranty.

Contact Lenses fees: Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes and require additional fees. These fees include additional cost for the contact lens evaluations, follow-up care, dispensing and contact lenses which are provided by our office.

Insurance assignment and release: I authorize payment of benefits directly to Dr. Lauren Dickerman and/or Harvard Square Eye Care, P.C. for services rendered. I also authorize the release of any medical information that may be required in determination of such benefits. I understand that some services may require approval or a referral from my primary care physician (PCP) for coverage and that I am responsible to obtain any and all referrals that my insurance company requires for services performed. If I do not obtain such approval, I am financially responsible for the services. I understand that my insurance carrier may not cover some services and products and therefore understand that I would be responsible for those charges. Deductibles and fees not paid by my insurance carrier will be my responsibility.

I acknowledge that I have read and understand Harvard Square Eye Care, P.C.'s office policy and received a copy of their "Notice of Privacy Practices HIPPA" policy.

_____/_____/_____
Patient Signature Date

www.HarvardSquareEyeCare.com

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617-354-5100

Central Square
Cambridge MA 02138
617-354-3600

Davis Square
N. Cambridge MA 02140
617-628-6800

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Cambridge MA 02138
617-354-5590

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Boston MA 02118
857-449-7181