Harvard Square Eye Care, P.C.

Exams • Eye Glasses • Contact Lenses

Patient Registration Form

Date: _____/_____/_____

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

Address: _____ Last Eye Exam: ____/____ ▪ Mobil Phone: _____
Month Year

City: _____ State: _____ Zip: _____ ▪ Secondary Phone: _____

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

Birth Date: _____/_____/_____ Social Sec Nº Last 4: XXX-XX-_____ Occupation: _____

Vision Insurance: _____ Primary Care Dr: _____
Carrier and member ID 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 Nº: _____ Social Sec Nº Last 4: XXX-XX-_____

Emergency Contact: ☐ Same as Primary subscriber _____ Phone: _____

Existing Conditions - Please select all that apply

- ☐ Age related macular degeneration (ARMD)
- ☐ Abnormal pupil
- ☐ Cataract
- ☐ Diabetes
- ☐ Diabetic retinopathy
- ☐ Borderline blood sugar
- ☐ Borderline eye pressure
- ☐ Glaucoma
- ☐ High / Hyper cholesterol
- ☐ Hypertension / high blood pressure
- ☐ Blood pressure - borderline
- ☐ None

Ocular History - Please select all that apply

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

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

- ☐ Arcus
- ☐ Astigmatism
- ☐ Blindness
- ☐ Choroidal melanoma
- ☐ Crossed eyes
- ☐ Dry eye
- ☐ Farsightedness
- ☐ Keratoconus
- ☐ Lazy eye
- ☐ Nearsightedness
- ☐ Night blindness
- ☐ Presbyopia
- ☐ Retinal detachment
- ☐ Retinitis pigmentosa

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.

- ☐ Acne
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Brain tumor
- ☐ Cancer
- ☐ Chronic bronchitis
- ☐ Chronic cough
- ☐ Depression
- ☐ Dry mouth / throat
- ☐ Emphysema
- ☐ Fever
- ☐ Fibromyalgia
- ☐ Hay fever
- ☐ Headaches / Migraines
- ☐ Heart disease
- ☐ HIV/AIDS
- ☐ Kidney/bladder disease
- ☐ Lupus
- ☐ Neurological disorder
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Weight loss/gain
- ☐ 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 Last physical exam: Date ____/____/____

☐ Yes ☐ No I am diabetic → Diagnosis: _____

☐ Yes ☐ No I have had an eye operation Date ____/____/____

☐ Yes ☐ No I have had an eye injury Date ____/____/____ Injury: _____

☐ Yes ☐ No I currently wear eye glasses Correct for: ☐ Distance ☐ Reading ☐ Distance and reading

☐ Yes ☐ No I currently wear contact lenses Type: _____

→ ☐ 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 _____

Family & Social

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

☐ Blindness	☐ Crossed eyes	☐ High blood pressure	☐ Retinal detachment
☐ Cancer	☐ Diabetes	☐ Lazy eye	☐ Retinal disease
☐ Cataracts	☐ Glaucoma	☐ Macular degeneration	☐ Thyroid disease

☐ Yes ☐ No I drive an automobile/motorcycle Marital Status: ☐ Single ☐ Married ☐ Widowed

☐ Yes ☐ No I consume alcohol Social Status: ☐ Living alone ☐ Living with family or friends

☐ Yes ☐ No I use tobacco products

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

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617-628-6800

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