CHICOPEE EYECARE, P.C.
113 Center Street · Chicopee, Massachusetts 01013 · (413) 592-7777
Katarzyna Babinski, O.D.
Brett P. Burns, O.D.
Camille Guzek-Latka, O.D.
David C. Momnie, O.D.

Patient Information Form

Patient Information

First Name _____ Last Name_____

Address _____

City _____ State _____Zip Code _____

DOB (mm/dd/yyyy) ___/____/_____ SSN# ____/____/_____

Gender: Male ☐ Female ☐ Preferred Phone# Cell☐Home ☐ Work ☐

Cell:_____ Home:_____ Work:_____

Email:_____

Insurance Information

Do you have health insurance Yes ☐ No ☐

If yes, insurance carrier _____

Insurance Subscriber _____ DOB ____/____/_____

Subscriber ID or SSN# _____

Is the reason for your visit today a result of an accident at work? Yes ☐ No ☐

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions

Constitutional	Yes	No
Developmental Disabilities	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
Other _____		

Ear/Nose/Mouth/Throat	Yes	No
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐
Other	☐	☐

Neurological	Yes	No
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐
Autism Spectrum Disorder	☐	☐
Other _____		

Psychiatric	Yes	No
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
Other _____		

Cardiovascular	Yes	No
Hypertension	☐	☐
Stroke / CVA	☐	☐
Heart disease	☐	☐
Congestive heart failure	☐	☐
Other _____		

Respiratory	Yes	No
Cigarette Smoker	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Chronic obstruction	☐	☐
Sleep apnea	☐	☐

Gastrointestinal	Yes	No
Crohn's	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Celiac Disease	☐	☐
Other _____		

Genito – urinary	Yes	No
Kidney disease	☐	☐
Prostate disease / cancer	☐	☐
STD – herpetic / chlamydia	☐	☐
Benign Prostate Hypertrophy	☐	☐
Pregnant (currently)	☐	☐
Nursing (currently)	☐	☐
Chlamydia	☐	☐
Other _____		

Musculoskeletal	Yes	No
Osteoarthritis	☐	☐
Arthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
Other _____		

Integumentary	Yes	No
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster / Shingles	☐	☐
Other _____		

Endocrine	Yes	No
Type 1 Diabetes Mellitus	☐	☐
Year of diagnosis _____		
Value of last A1C _____		
Type 2 Diabetes Mellitus	☐	☐
Year of diagnosis _____		
Thyroid dysfunction	☐	☐
Hormonal disfunction	☐	☐
Other _____		

Hematologic / Lymphatic	Yes	No
Anemia	☐	☐
Large volume blood loss	☐	☐
Ulcer	☐	☐
High Cholesterol	☐	☐

Allergic / Immune	Yes	No
Drug allergies	☐	☐
Environmental allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐
Other _____		

Patient Information Form

Primary Care Physician

Full Name _____ Address _____

Phone Number _____ City _____ State _____ Zip code_____

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each:

_____

_____

_____

_____

_____

_____

Allergies to Medication No allergies to Medications ☐

List any allergies you might have and the associated reaction:

_____

_____

_____

Other Allergies No Other allergies ☐

List any allergies you might have and the associated reaction:

_____

_____

Patient Ocular History	Yes	No		Yes	No
Glaucoma	☐	☐	Strabismus	☐	☐
Glaucoma Suspect	☐	☐	Amblyopia	☐	☐
Cataract	☐	☐	Retinal Degeneration/Hole/Detachment	☐	☐
Age-related Macular degeneration	☐	☐	Keratoconus	☐	☐
Surgery	☐	☐	Injury	☐	☐
Patching	☐	☐	Dry eye	☐	☐
Inflammatory disorder	☐	☐	Nystagmus	☐	☐
			Other _____		

Social history

Are you a drug user Yes ☐ No ☐

Are you a: Non-Drinker ☐ Social Drinker ☐

Tobacco Use (mark which one applies)

Heavy smoker ☐ Light Smoker ☐

Never Smoked ☐ Former Smoker ☐

Family Medical History

	Yes	No	Relationship
Cancer	☐	☐	_____
Type 1 Diabetes Mellitus	☐	☐	_____
Type 2 Diabetes Mellitus	☐	☐	_____
Hyperthyroidism	☐	☐	_____
Hypertension	☐	☐	_____
Hypothyroidism	☐	☐	_____

Other _____

Family Ocular History

	Yes	No	Relationship
Cataract	☐	☐	_____
Degenerative disorder of macula	☐	☐	_____
Glaucoma	☐	☐	_____

Contact Lens History

Lens type: Soft ☐ RPG/hard lens ☐ Hybrid ☐

Contact Lens brand _____

Contact Lens Rx R _____

L _____

How many hours a day do you wear your contacts? _____

How often do you replace your contacts Daily ☐ Biweekly ☐ Monthly ☐ Other _____

Do You wear your contacts overnight? Yes ☐ No ☐

What solution do you use to clean your contacts? _____

Please list all major surgeries or injuries you have had in the past:

Authorization & Release of Benefits

I hereby authorize direct payment of benefits to Chicopee Eyecare, P.C. for services rendered by the providers. I authorize the release of any medical information that maybe required in determination of such benefits. I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for the services. I understand that I am financially responsible for any balances not covered by my insurance, including co-pays, deductibles, contact lens evaluations fees, refractions, diagnostic testing, and products such as glasses and contact lens.

Signature of Responsible Party _____ Date _____

I acknowledge that I received a copy of Chicopee Eyecare, P.C. "Notice of Privacy Act, HIPPA policy"

Signature of Responsible Party _____ Date _____