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

First Name__________________Last Name_____________________
Address____
City______________________State______Zip Code____________
DOB (mm/dd/yyyy)____/_____/_______SSN#______/______/______
Gender: Male ☐ Female ☐ Preferred # Home☐ Work ☐ Cell☐
Home Phone____________________Cell______________________
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 visit today a result of an accident at work? Yes☐ No☐ If yes, claim number___________________________

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_______________		
Ears/Nose/Mouth/Throat		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐
Other_______________		
Neurological		
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Celebral Palsy	☐	☐
Tumor	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐
Autism Spectrum Disorder	☐	☐
Other_______________		
Psychiatric		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
Other_______________		

Cardiovascular	Yes	No
Hypertension	☐	☐
Stroke/CVA	☐	☐
Heart Disease	☐	☐
Congestive Heart Failure	☐	☐
Other_______________		
Respiratory		
Cigarette Smoker	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Chronic Obstruction	☐	☐
Sleep Apnea	☐	☐
Other_______________		
Gastrointestinal		
Crohn's	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Acid Reflex	☐	☐
Celiac Disease	☐	☐
Other_______________		

Genito-urinary	Yes	No
Kidney disease	☐	☐
Prostate disease/cancer	☐	☐
STD - herpetic/chlamydia	☐	☐
Benign Prostate Hypertrophy	☐	☐
Pregnant	☐	☐
Nursing	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐
Other_______________		
Musculoskeletal		
Osteoarthritis	☐	☐
Arthritis	☐	☐
Fibromayalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
Other_______________		
Integumentary		
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______		
Value of last A1C______		
Thyroid dysfunction	☐	☐
Hormonal dysfunction	☐	☐
Other_______________		
Hemotologic/Lymphatic		
Anemia	☐	☐
Large-volume blood loss	☐	☐
Ulcer	☐	☐
Hypercholesteremia	☐	☐
Other_______________		
Allergic/Immune		
Drug Allergies	☐	☐
Environmental Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐
Other_______________		

Primary Care Physician

Full Name____
Phone Number____
Address____
City______________________State______Zip Code____________

Medications

No Medications ☐

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

____
____
____
____
____
____
____

Allergies to Medications

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.

____
____
____

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Patient Ocular History

	Yes	No
Glaucoma	☐	☐
Glaucoma Suspect	☐	☐
Cataract	☐	☐
Age-related Macular Degeneration	☐	☐
Surgery	☐	☐
Patching	☐	☐
Inflammatory Disorder	☐	☐

	Yes	No
Strabismus	☐	☐
Amblyopia	☐	☐
Retinal Degeneration/Hole/Detachment	☐	☐
Keratoconus	☐	☐
Injury	☐	☐
Dry Eye	☐	☐
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 tobacco smoker ☐ Light tobacco smoker☐

Never a smoker ☐ Former Smoker ☐

Other____________________________________

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 ☐ RGP/hard lens ☐ Hybrid ☐

Contact Lens Brand______________________

Contact Lens Rx OD____________________

O S____________________

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

How often do you replace your contacts? Daily☐ Bi-weekly☐ Monthy☐ 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.

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Authorization & Release of Benefits

I hereby authorize direct payment of benefits to Chicopee Eyecare, P.C. for services rendered by the providers. 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 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 balance not covered by my insurance, including co-pays, deductibles, contact lens evaluation fees, refractions, diagnostic testing, and products purchased such as glasses and contact lenses.

Signature of Responsible Party_______________________________________Date_____________________

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

Signature of Responsible Party_______________________________________Date_____________________