CHICOPEE
—EYECARE—

113 Center Street ● Chicopee, Massachusetts 01013 ● (413) 592-7777

Patient Information

First Name _____ Last Name_____

Address _____

City _____ State _____ Zip Code _____

DOB (mm/dd/yyyy) _____/_____/_____ Last 4 of SSN# _____

Gender: _____ Preferred Phone# Cell ☐ Home ☐ Work ☐

Cell:_____ Home:_____ Work:_____

Email:_____

Occupation: _____

Preferred Pharmacy: _____

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? Please check all that apply.

Constitutional
□ Developmental Disabilities
□ Cancer
□ Fatigue Syndrome
□ Other:

Ear/Nose/Mouth/Throat
□ Hearing Loss
□ Sinusitis
□ Dry Mouth
□ Laryngitis
□ Other:

Neurological
□ Multiple Sclerosis
□ Epilepsy
□ Cerebral Palsy
□ Tumor
□ Stroke/CVA
□ Migraine
□ Autism Spectrum Disorder
□ Other:

Psychiatric
□ Depression
□ Attention Deficit
□ Anxiety Disorder
□ Bipolar Disorder
□ Other

Cardiovascular
□ Hypertension
□ Stroke/CVA
□ Heart Disease
□ Congestive heart failure
□ Other:

Respiratory
□ Cigarette smoker
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic obstruction sleep apnea

Gastrointestinal
□ Chron's
□ Colitis
□ Ulcer
□ Acid Reflux
□ Celiac Disease
□ Other:

Genito-urinary
□ Kidney Disease
□ Prostate Disease/cancer
□ STD – herpetic/chlamydia
□ Benign Prostate Hypertrophy
□ Pregnant (currently)
□ Nursing (currently)
□ Chlamydia
□ Other:

Musculoskeletal
□ Osteoarthritis
□ Arthritis
□ Fibromyalgia
□ Muscular Dystrophy
□ Ankylosing Spondylitis
□ Osteoporosis
□ Gout
□ Other:

Integumentary
□ Eczema
□ Rosacea
□ Psoriasis
□ Herpes Simplex/Cold Sores
□ Herpes Zoster/Shingles
□ Other:

Endocrine
□ Type 1 Diabetes Mellitus
- Year of Diagnosis _____
- Last A1C _____
□ Type 2 Diabetes Mellitus
- Year of Diagnosis _____
- Last A1C _____
□ Thyroid dysfunction
□ Hormonal dysfunction
□ Other:

Hematologic/Lymphatic
□ Anemia
□ Large volume blood loss
□ Ulcer
□ High Cholesterol

Allergic/Immune
□ Drug Allergies
□ Environmental allergies
□ Rheumatoid arthritis
□ Lupus
□ Sjogren's Syndrome
□ Other

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Patient Ocular History
□ Glaucoma
□ Glaucoma Suspect
□ Cataract
□ Age-related Macular Degeneration
□ Surgery
- please describe:
□ Patching
□ Inflammatory disorder
□ Strabismus
□ Amblyopia
□ Retinal Degeneration
□ Retinal Hole
□ Retinal Detachment
□ Keratoconus
□ Injury
- please describe:
□ Dry eye
□ Nystagmus
□ Other:

Social History
□ Drug user
□ Non-drinker □ Social Drinker
□ Never Smoker
□ Heavy Smoker
□ Light Smoker
□ Former Smoker

Major Surgeries
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Contact Lens History
□ Soft □ RGP/Hard lens □ Hybrid
Contact lens brand: _____
Contact lens Rx
Right eye:
Left eye:
How many hours per 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?

Family Medical History **Relationship**
□ Cancer _____
- please describe:
□ Type 1 Diabetes Mellitus _____
□ Type 2 Diabetes Mellitus _____
□ Hyperthyroidism _____
□ Hypothyroidism _____
□ Hypertension _____
□ Other: _____

Family Ocular History **Relationship**
□ Cataract _____
□ Degenerative disorder of macula _____
□ Glaucoma _____

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
List any allergies you might have and the associated reaction:
_____

Authorization & Release of Benefits
I hereby authorize direct payment of benefits to Chicopee Eyecare for services rendered by the providers. I 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 balances not covered by my insurance, including co-pays, deductibles, contact lens evaluation fees, refractions, diagnostic testing, and products such as glasses and contact lenses. I acknowledge that I received a copy of Chicopee Eyecare "Notice of Privacy Act, HIPPA policy"

Signature of Responsible Party _____ Date _____