

PATIENT REGISTRATION

James C. Frangos, OD
C. Andrew Frangos, OD

15 Portland Avenue, Dover NH 03820
603-742-7371

Date _____ Name _____
Last Name First Middle Initial

Sex Male Female Age _____ Date of Birth _____ Last 4 SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Permission to send text reminders Yes No

Email _____ Permission to send email reminders Yes No

Married Widowed Single Divorced Separated Minor Partnered for _____ Years

Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone(____) _____

In case of emergency who should be notified? _____ Relationship _____

Phone (____) _____

Whom may we thank for referring you? _____

Copy of Vision Insurance Card (office use)	Vision Insurance Information
	Relationship to Primary Person on plan _____
	Name _____
	Date of Birth _____ Last 4 SSN _____
	Address _____ _____
	Phone(____) _____
	Patient to Review Insurance each visit
	Initials _____ Date _____ Initials _____ Date _____
	Initials _____ Date _____ Initials _____ Date _____
	Initials _____ Date _____ Initials _____ Date _____
Copy of Primary Medical Insurance Card (office use)	Medical Insurance Information
	Relationship to Primary Person on plan _____
	Name _____
	Date of Birth _____ Last 4 SSN _____
	Address _____ _____
	Phone(____) _____
	Patient to Review Insurance each visit
	Initials _____ Date _____ Initials _____ Date _____
	Initials _____ Date _____ Initials _____ Date _____
	Initials _____ Date _____ Initials _____ Date _____

Release

I certify that I, and or my dependent(s), have insurance coverage with the above Insurance Company(ies) and assign directly to Drs. James and Andrew Frangos all insurance benefits, if any, otherwise payable to me for services rendered. Initials _____

I understand that I am financially responsible for all charges whether or not paid by insurance. Initials _____

I understand that there is a billing fee of \$5.00 added on to any outstanding bill not paid within 30 days. Initials _____

I authorize the use of my signature on all insurance submissions. The above-named doctor(s) may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. Initials _____

Signature of Patient, Parent, Guardian or Personal Representative

Date

MEDICATIONS / ALLERGIES	HEALTH HABITS
List Medications you are currently taking _____ _____ _____ _____ Pharmacy _____ Phone _____ List allergies to medications or substances _____	Check (✓) which you use and how much: <input type="checkbox"/> Caffeine _____ <input type="checkbox"/> Street Drugs _____ <input type="checkbox"/> Tobacco _____ Check (✓) if your work exposes you to: <input type="checkbox"/> Stress <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Hazardous Substances

Name of Primary Care Physician _____
Medical Group Name and City/State _____

EYE HEALTH HISTORY

Previous Optometrist _____ Date of last eye exam _____ Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> All the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Reading <input type="checkbox"/> Driving	Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Hours per Day _____ Describe any problems with your contact lenses _____ _____
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Check (✓) symptoms you currently have or have had in the past year:

<input type="checkbox"/> Blurred Vision - Distance	<input type="checkbox"/> Discharge from eyes	<input type="checkbox"/> Floaters or Spots	<input type="checkbox"/> Fainting Spells, Blackouts	<input type="checkbox"/> Temporary Loss of Vision
<input type="checkbox"/> Blurred Vision - Near	<input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Watery Eyes
<input type="checkbox"/> Burning Eyes	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Seeing Halos	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Seeing Flashes	_____
<input type="checkbox"/> Color Vision	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Twitching Eyelid	_____
<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Vision Poor	_____
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Night Vision, Poor			

MEDICAL HISTORY Check (✓) symptoms you currently have or have had:

GASTROINTESTINAL	CARDIOVASCULAR	EAR/NOSE/THROAT	SKIN	WOMEN ONLY:
<input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Chest Pain <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Irregular/Rapid heart beat <input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Earache/Ear discharge <input type="checkbox"/> Hay Fever <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems	<input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash <input type="checkbox"/> Change in moles	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No # of Children: _____
GENERAL <input type="checkbox"/> AIDS <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Cancer <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> COPD <input type="checkbox"/> Depression/Nervousness <input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Gout <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Lupus <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Numbness <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Rosacea <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Temporal Arteritis <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Other: _____	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ Print name of Patient, Parent, Guardian	_____ Relationship to Patient
_____ Signature	_____ Date

I acknowledge that I have seen a copy of the Privacy Practices and know I can receive a copy if requested:

_____ Signature	_____ Date
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