# PATIENT REGISTRATION

COCHECO EYE CARE
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** _____<br>**Name**_____<br>**Date of Birth** _____ **Last 4 SSN** _____<br>**Address** _____<br>_____<br>**Phone(**_____**)**_____ |
| | **Patient to Review Insurance each visit** |
| | **Initials** _____ **Date**_____ **Initials** _____ **Date**_____<br>**Initials** _____ **Date**_____ **Initials** _____ **Date**_____<br>**Initials** _____ **Date**_____ **Initials** _____ **Date**_____ |
| **Copy of Primary Medical Insurance Card (office use)** | **Medical Insurance Information** |
| | **Relationship to Primary Person on plan** _____<br>**Name**_____<br>**Date of Birth** _____ **Last 4 SSN** _____<br>**Address** _____<br>_____<br>**Phone(**_____**)**_____ |
| | **Patient to Review Insurance each visit** |
| | **Initials** _____ **Date**_____ **Initials** _____ **Date**_____<br>**Initials** _____ **Date**_____ **Initials** _____ **Date**_____<br>**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

**List Medications you are currently taking**

_____

_____

_____

_____

**Pharmacy**_____ **Phone** _____

**List allergies to medications or substances** _____

_____

## HEALTH HABITS

**Check (✓) which you use and how much:**

- ☐ **Caffeine** _____
- ☐ **Street Drugs** _____
- ☐ **Tobacco** _____

**Check (✓) if your work exposes you to:**

- ☐ **Stress**
- ☐ **Heavy Lifting**
- ☐ **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? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving

Do you wear contacts? ☐ Yes ☐ No

Type _____

Hours per Day _____

Describe any problems with your contact lenses _____

_____

Check (✓) symptoms you currently have or have had in the past year:

| | | | | |
|---|---|---|---|---|
| ☐ Blurred Vision - Distance | ☐ Discharge from eyes | ☐ Floaters or Spots | ☐ Fainting Spells, Blackouts | ☐ Temporary Loss of Vision |
| ☐ Blurred Vision - Near | ☐ Dizzy Spells | ☐ Glaucoma | ☐ Red Eyes | ☐ Watering Eyes |
| ☐ Burning Eyes | ☐ Double Vision | ☐ Itchy Eyes | ☐ Seeing Halos | ☐ Other: _____ |
| ☐ Cataracts | ☐ Dry Eyes | ☐ Light Sensitivity | ☐ Seeing Flashes | _____ |
| ☐ Color Vision | ☐ Eye Infection | ☐ Loss of Vision | ☐ Twitching Eyelid | _____ |
| ☐ Crossed Eyes | ☐ Eye Injury | ☐ Migraine Headaches | ☐ Vision Poor | _____ |
| | ☐ Eye Strain | ☐ Night Vision, Poor | | |

## MEDICAL HISTORY

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

| GASTROINTESTINAL | CARDIOVASCULAR | EAR/NOSE/THROAT | SKIN | WOMEN ONLY: |
|---|---|---|---|---|
| ☐ Indigestion | ☐ Chest Pain | ☐ Earache/Ear discharge | ☐ Hives | Pregnant ☐ Yes ☐ No |
| ☐ Nausea | ☐ High/Low blood pressure | ☐ Hay Fever | ☐ Itching/Rash | # of Children: _____ |
| ☐ Stomach pain | ☐ Irregular/Rapid heart beat | ☐ Loss of hearing | ☐ Change in moles | |
| ☐ Vomiting | ☐ Poor Circulation | ☐ Ringing in ears | | |
| ☐ Vomiting blood | | ☐ Sinus problems | | |

| GENERAL | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Dizziness/Fainting | ☐ Liver Disease | ☐ Prostate Problem |
| ☐ Anemia | ☐ Emphysema | ☐ Loss of sleep | ☐ Rheumatic Fever |
| ☐ Arthritis | ☐ Epilepsy | ☐ Loss of weight | ☐ Rheumatoid Arthritis |
| ☐ Asthma | ☐ Fever | ☐ Lupus | ☐ Rosacea |
| ☐ Bleeding Disorders | ☐ Forgetfulness | ☐ Lyme Disease | ☐ Scarlet Fever |
| ☐ Breast Lump | ☐ Gout | ☐ Measles | ☐ Sleep Apnea |
| ☐ Cancer | ☐ Headaches | ☐ Migraine Headaches | ☐ Stroke |
| ☐ Chemical Dependency | ☐ Heart Disease | ☐ Multiple Sclerosis | ☐ Temporal Arteritis |
| ☐ Chicken Pox | ☐ Hepatitis | ☐ Mumps | ☐ Thyroid Problems |
| ☐ COPD | ☐ Herpes | ☐ Numbness | ☐ Tuberculosis |
| ☐ Depression/Nervousness | ☐ High Cholesterol | ☐ Pacemaker | ☐ Ulcers |
| ☐ Diabetes | ☐ HIV Positive | ☐ Pneumonia | ☐ Venereal Disease |
| | ☐ Kidney Disease | ☐ Polio | ☐ 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**