PATIENT REGISTRATION

COCHECO EYE CARE

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

C. Andrew Fra	angos, OD						603-742-7371
Date	Name	Last Name		First			Middle Initial
Sex 🗆 Male	□ Female	Age	Date of Birth			SSN	
		·					
							Zip
							iinders □ Yes □ No
Email					Permission to	send email re	eminders 🗆 Yes 🗆 No
□ Married	□ Widowed	d Single	□ Divorced	□ Separated	□ Minor	□ Partnered	d for Years
Employer/Scl	hool				Occupation_		
Employer/Scl	hool Address			Ε	mployer/Scho	ol Phone ()
In case of em	ergency, who	should be notifi	ed?				
Name			Relationshi	ip		_ Phone ()
Insurance	Information						
Insurance C	Company:				Insurance	e ID#:	
Secondary	Insurance Co	mpany:			Insuranc	e ID#:	
		n (if not the pati	ent)				
	elationship to	Guarantor:					
Name:					Date of E	Birth:	
Address:							
Release							
	•		insurance coverag fits, if any, otherwi			•••	
I understand	that I am finan	cially responsible	for all charges not	paid by insurance	Ce.		Initials
I understand	that there is a	billing fee of \$5.00) added on to any	outstanding bill r	ot paid within 3	80 days.	Initials
may disclose	such informat	ion to the above n		Company(ies) and	their agents fo	• •	h care information and of obtaining payment Initials
	on for Dalas			ation			
Authorizati	ion for Kelea	se of identifying	g Health Informa			·// /D · · ·	

The staff has per	mission to: (Check all that apply)	The staff has my permission to talk with: (Provide name & phone)		
Leave a voicem	ail at home	Spouse/Significant Other		
Leave a voicem	ail on my cell	Children		
Other:		Parent		
The staff has permission to email/fax the following when verbally or otherwise requested:				
Invoices	Itemized Receipts	Prescriptions		

List Medications/Vitamins you are currently taking: List Medications/Vitamins you are currently taking: Check (~) which you use and how much: Cafaine Tobacco Cafaine Tobacco Check (~) if your work exposes you to: Stress List allergies to medications or substances Heavy Lifting Hours per Day Hours per Heaters Hours Per Day Hours per Da	MEDICATIONS / ALI	LERGIES		HEALTH I	HABITS	
□ □	List Medications/Vita	mins you are currently	taking:		ffeine	
List allergies to medications or substances				🗆 🗆 Tol	bacco	
List allergies to medications or substances				• • •		ou to:
Name of Primary Care Physician Wedical Group Name and City/State EYE HEALTH HISTORY Previous Optometrist Do you wear glasses? Pate of last eye exam Do you wear glasses? Previous Optometrist Do you wear glasses? Previous Optometrist Do you wear glasses? Previous Optometrist De you wear glasses? Previous Optometrist Burned Vision - Near Double Vision Class Vision Class Vision Discharge from Eyes Preview Class Vision Discharge from Eyes Produer or Spoit Feater Strometrist Discharge from Eyes Produer Pre	List allergies to medications or substances			Heavy Lifting		
Name of Primary Care Physician Wedical Group Name and City/State EYE HEALTH HISTORY Previous Optometrist Do you wear glasses? Pate of last eye exam Do you wear glasses? Previous Optometrist Do you wear glasses? Previous Optometrist Do you wear glasses? Previous Optometrist De you wear glasses? Previous Optometrist Burned Vision - Near Double Vision Class Vision Class Vision Discharge from Eyes Preview Class Vision Discharge from Eyes Produer or Spoit Feater Strometrist Discharge from Eyes Produer Pre	Pharmacy				Phone	
EYE HEALTH HISTORY Previous Optometrist	Name of Primary Care Medical Group Name	e Physician				
Date of last eye exam Type Do you wear glasses? Yes I No Dat the time Occasionally Describe any problems with your contact lenses Reading Driving Check (<') symptoms you currently have or have had in the past year:						
Date of last eye exam Type Do you wear glasses? Yes I No Dat the time Occasionally Describe any problems with your contact lenses Reading Driving Check (<') symptoms you currently have or have had in the past year:				Do you wea	r contacts? 🗆 Yes 🗆 No	
Do you wear glasses? I Yes No Hours per Uay Describe any problems with your contact lenses I All the time Occasionally Describe any problems with your contact lenses Describe any problems with your contact lenses Check (Y) symptoms you currently have or have had in the past year: Describe any problems with your contact lenses Blurred Vision - Distance Dizzy Spells Glaucoma Red Eyes Other: Blurred Vision - Near Double Vision Ittry Eyes Seeing Flashes Describe any problems with your contact lenses Cataracts Eye Infection Loss of Vision Twithing Eyeid Describe any problems with your contact lenses Color Vision Eye Infection Loss of Vision Twithing Eyeid Description Cost Vision Eye Infection Loss of Vision Twithing Eyeid Description Orseade Eyes Expensively have or have had: Women OnLY: Pregnant I Yes INO MEDICAL HISTORY Charle for Discharge Hives Pregnant I Yes INO Indigestion Indigestion EARNOSE/THROAT SKin WOMEN ONLY: Nausea Hight-Radd Heart Beat Bringin in Ears Sinos Problems # of Children: Pregnant I Yes INO <	Date of last eye exam			Туре		
□ Reading □ Driving Check (✓) symptoms you currently have or have had in the past year: □ □ Blurred Vision - Distance □ Dizy Spells □ Glaucoma □ Red Eyes □ Other: □ □ Blurred Vision - Near □ Double Vision □ Itchy Eyes □ Seeing Flashes □ □ □ Cataracts □ Dry Eyes □ Loss of Vision □ Twitching Eyelid □ □ □ Color Vision □ Eye Injury □ Migraine Headaches □ Vision Poor □ Temporary Loss of Vision □ □ Color Vision □ Eye Injury □ Migraine Headaches □ Vision Poor □ □ Temporary Loss of Vision □ Color Vision □ Eye Injury □ Migraine Headaches □ Vision Poor □ □ □ Chach HSTORY Check (✓) symptoms you currently have or have had: □	Do you wear glasses? 🗆	Yes 🗖 No		Hours per D	ay	
Check (v) symptoms you currently have or have had in the past year: Image: Check (v) symptoms you currently have or have had in the past year: Blurred Vision - Distance Dizzy Spells Claucoma Red Eyes Other: Blurred Vision - Near Double Vision Inthy Eyes Seeing Halos Image: Check (v) Burning Eyes Dy Eyes Light Sensitivity Seeing Flashes Image: Check (v) Cotaracts Eye Infection Loss of Vision Twitching Eyeld Image: Check (v) Cotor Vision Eye Injury Migraine Headaches Vision Poor Image: Check (v) Cotor Vision Eye Infection or Spots Fainting Spells, Blackouts Watering Eyes Image: Check (v) symptoms you currently have or have had: CASTROMTESTINAL Chest Pain Earache/Ear Discharge Hives Itching/Rash Pregnant Yes INO Stomach Pain Imagua/Ragh Hear Beat Loss of Vision Change in Moles # of Children: Pregnant Yes INO Chest Pain Inizariess/Fainting Liver Disease Prostate Problem Anomia Stomach Pain Imagua/Ragh Interns Liver Disease Prostate Problem Anomia Adding Bl				Describe an	y problems with your co	ntact lenses
□ Blurred Vision - Distance □			vo had in tho n			
Blurred Vision - Near Double Vision Itchy Eyes Seeing Halos Burring Eyes DP Eyes Light Sensitivity Seeing Halos Cataracts Eye Infection Loss of Vision Twitching Eyelid Color Vision Eye Infection Loss of Vision Poor Twitching Eyelid Color Vision Eye Injury Migraine Headaches Vision Poor Cossed Eyes Eye Strain Night Vision, Poor Temporary Loss of Vision Discharge from Eyes Floaters or Spots Fainting Spells, Blackouts Watering Eyes MEDICAL HISTORY Check (Symptoms you currently have or have had: Stima Pregnant Pies CARNIOVASCULAR Earache(Ear Discharge Hives Pregnant Pies No Nausea HighLow Blood Pressure Hay Fever Btthing/Rash # of Children: Poor Circulation Vomiting Poor Circulation Sinus Problems Change in Moles # of Children: Pregnant Pies AlDS Emphysema Loss of sleep Rheumatic Fever Rosacea Scale Froblem AlDS Epilepsy Loss of sleep Rheumatic Fever Rosacea Scal		-			Pod Eves	C Other:
Burning Eyes Dry Eyes Light Sensitivity Seeing Flashes Cataracts Eye Infection Loss of Vision Twitching Eyelid Color Vision Eye Infection Loss of Vision Twitching Eyelid Color Vision Eye Injury Migraine Headaches Vision Poor Crossed Eyes Floaters or Spots Fainting Spells, Blackouts Watering Eyes Indigestion Check (Symptoms you currently have or have had: CASTROINTESTINAL CARDIOVASCULAR EarcheleTa Discharge Hives Nausea Hightow Blood Pressure Hay Fever Itching/Rash Stomach Pain Irregular/Rapid Heart Beat Loss of Hearing Change in Moles # of Children: Vomiting Blood Dizziness/Fainting Liver Disease Prostate Problem # of Children: Anemia Epiepsy Loss of sleep Rheumatic Fever # of Children: # of Children: Asthma Fever Lupus Rosacea Strike Genet Fever Bleeding Disorders Gout Measles Strike Strike Strike Cancer Heart Disease Multiple Sclerosis <td></td> <td></td> <td></td> <td></td> <td>•</td> <td></td>					•	
□ Cataracts □ Eye Infection □ Loss of Vision □ Twitching Eyelid □ Cotor Vision □ Eye Injury □ Migraine Headaches □ Vision Poor □ Crossed Eyes □ Eye Strain □ Night Vision, Poor □ Temporary Loss of Vision □ Discharge from Eyes □ Floaters or Spots □ Faining Spells, Blackouts □ Watering Eyes MEDICAL HISTORY Check (✓) symptoms you currently have or have had:					-	
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GASTROINTESTINAL CARDIOVASCULAR EAR/NOSE/THROAT SKIN WOMEN ONLY: Indigestion Chest Pain Earache/Ear Discharge Hives Pregnant Yes No Stomach Pain Irregular/Rapid Heart Beat Loss of Hearing Change in Moles # of Children:						
Indigestion Chest Pain Earache/Ear Discharge Hives Pregnant Yes No Nausea High/Low Blood Pressure Ray Fever Itching/Rash of Children: ////////////////////////////////////						I
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Vomiting Poor Circulation Ringing in Ears Vomiting Blood Sinus Problems GENERAL Dizziness/Fainting Liver Disease Prostate Problem AIDS Emphysema Loss of sleep Rheumatic Fever Anemia Epilepsy Loss of sleep Rheumatic Fever Antritis Fever Lupus Rosacea Athritis Fever Lupus Rosacea Bleeding Disorders Gout Measles Sleep Apnea Breast Lump Headaches Migraine Headaches Stocke Cancer Heart Disease Multiple Sclerosis Temporal Arteritis Chenical Dependency Hepatitis Mumps Thyroid Problems Chicken Pox Herpes Numbness Tuberculosis COPD High Cholesterol Pacemaker Ulcers Diabetes 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's office if I, or my minor child, ever have a change in address, phone, insurance or health. Print name of Patient, Parent, Guardian Date					v v	# of Children:
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Depression/Nervousness HIV Positive Diabetes Kidney Disease Polio To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor's office if I, or my minor child, ever have a change in address, phone, insurance or 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.		•				
Diabetes Kidney Disease Polio To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor's office if I, or my minor child, ever have a change in address, phone, insurance or 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.		•				
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I acknowledge that I have seen a copy of the Privacy Practices and know I can receive a copy if requested.		Print name of Patient, Parent, Gu	ardian		Rela	tionship to Patient
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