Welcome to Brighton Eye Associates!

Mr. Dr. Last Name Ms. Mrs.	First Name & Middle Initial	Nickname	Date
Address	City	State & Zip	E-Mail Address
Place of Employment (Or School)	Type of Work (Or Grade)	Date of Birth & Age	Social Security Number
If Minor, Parent Name	Cell Phone	Home Telephone	Work Telephone May we contact you at work? Y / N

What is the major purpose of today's visit?

_____

VERY IMPORTANT!

Whom may we thank for referring you to our office?

Name of friend or relative: _____

If not referred, how did you choose our office for your needs?

- ☐ Saw Sign / Building
- ☐ Insurance List
- ☐ Newspaper / Radio / TV / Yellow Pages
- ☐ Web Pages: Which web site? _____
- ☐ Other:

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber ID#/SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID#/SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account? ☐ Yes ☐ No

How will you settle your account today? ☐ Cash ☐ Check ☐ Credit

Name of Family Physician / PCP _____

CURRENT MEDICATIONS (Rx or Over the Counter)

(Please list names of medications including eye drops, vitamins, and birth control)

_____

Emergency Contact _____

Relationship _____

Daytime Telephone / Cell Phone _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____

By Whom?_____

Have you ever worn contact lenses? ☐ Y ☐ N

Do you currently wear contact lenses? ☐ Y ☐ N

What kind? _____

Are you interested in contact lenses today? ☐ Y ☐ N

Are you interested in ordering new glasses? ☐ Y ☐ N

Do you… (Check if you answer is Yes)

☐ Work at a computer? How much? _____ hrs/wk.

☐ Spend time outdoors? How much? _____ hrs/wk.

☐ Want information on refractive surgery?

Have you ever been diagnosed or treated for any of the following?

☐ Cataracts	☐ Macular Degeneration
☐ Corneal Abrasion	☐ Retinal Detachment
☐ Eye Infection	☐ Glaucoma
☐ Eye Injury	☐ Iritis/Uveitis
☐ Lazy Eye	☐ Other _____

Do you experience or have you ever experienced?

☐ Floaters / spots	☐ Flash of Light
☐ Burning	☐ Grittiness
☐ Tearing	☐ Itchiness
☐ Headaches	☐ Crossed eye / eye turn
☐ Double Vision	☐ Trouble seeing at night
☐ Blurry Vision (Distance / Near)	☐ Bothered by Glare

**Please see reverse side →

CASE HISTORY

Review of Systems **Name:** _____ **Date: / /**

Please mark the significant health history form below:

Constitutional ☐ None
☐ Developmental disability
☐ Weight Loss
☐ Fever
☐ Fatigue
☐ Trauma
☐ Other / Medications:

Ears, Nose, Mouth & Throat ☐ None
☐ Upper respiratory tract infection
☐ Other / Medications:

Cardiovascular ☐ None
☐ Heart disease
☐ Hypertension
☐ Stroke
☐ Vascular disease
☐ Other / Medications:

Respiratory ☐ None
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Other / Medications:

Gastrointestinal ☐ None
☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Digestive
☐ Other / Medications:

Genitourinary ☐ None
☐ Urinary tract infections
☐ Kidney ailments
☐ STD: Herpes, Chlamydia, HIV
☐ Other / Medications:

Musculoskeletal ☐ None
☐ Fibromyalgia
☐ Muscular dystrophy
☐ Osteoarthritis
☐ Other / Medications:

Integumentary ☐ None
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Other / Medications:

Neurological ☐ None
☐ Multiple Sclerosis
☐ Epilepsy
☐ Other / Medications:

Psychiatric ☐ None
☐ Depression
☐ Panic disorder
☐ Schizophrenia
☐ Other / Medications:

Endocrine ☐ None
☐ Diabetes
☐ Thyroid dysfunction
☐ Hormonal dysfunction
☐ Other / Medications:

Blood / Lymphatic ☐ None
☐ Anemia
☐ Leukemia
☐ Other / Medications:

Allergic / Immunologic ☐ None
☐ Drug allergy
☐ Environmental allergy
☐ Rheumatoid arthritis
☐ Lupus
☐ Other / Medications:

Social History

Do you use tobacco products? ☐ Yes ☐ No If yes, type / amount / how long: _____
Do you drink alcohol? ☐ Yes ☐ No If yes, type / amount / how long: _____
Do you use illegal drugs? ☐ Yes ☐ No If yes, type / amount / how long: _____
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None

Family History

Is there any family medical history of any of the following? (If yes, please list the relationship to you). ☐ None

☐ Blindness _____ ☐ Corneal Problems _____
☐ Cataracts _____ ☐ Lazy Eye _____
☐ Glaucoma _____ ☐ Diabetes _____
☐ Macular Degeneration _____ ☐ Heart Disease _____
☐ Retinal Detachment _____ ☐ Other Hereditary Diseases _____

Payment is Due at Time Services Are Rendered

For your health Safety, we perform annual contact lens evaluations. A separate contact lens fee, (starting at $50.00), is charged beyond the comprehensive eye examination. Your doctor determines the fit, health and condition of the eyes with contact lenses. We also evaluate the changes in prescription and lens design during this process.

A Warning Regarding Eye Dilation

As part of each comprehensive eye examination, it is necessary to dilate the pupils of the eye. This may hinder your ability to see up close for 3-4 hours and may increase sensitivity to light.

Delinquent Accounts

I hereby authorize any necessary medical treatment by Dr. Kristen Banek in the practice of Brighton Eye Associates and agree to be responsible for my bill and any collection fees incurred by Brighton Eye Associates in attempt to collect payments of materials and/or services rendered. I authorize the office of Brighton Eye Associates to release or obtain any required medical information from my attending physicians or medical facility. I also authorize Brighton Eye Associates to file my insurance and collect payment on my behalf.

A Warning Regarding Pregnancy

If you are nursing, pregnant, or think you may be, please notify the staff and doctor prior to receiving any eye drops.

Signature _____ Date_____

Kristen Banek, O.D.
372 Washington St.
Brighton, MA 02135
Tel. (617) 782-6650
Fax (617) 782-2660

Brighton Eye Associates

RETINAL PHOTOGRAPHY EXAM

Brighton Eye Associates now employs a highly sophisticated computerized instrument that allows us to provide additional medical analysis of the inside layer of your eye, the retina. In 2007 The National Eye Institute reported that the occurrence of eye disease in Americans was increasing at a significant rate. Specifically, glaucoma, macular degeneration, and diabetic eye disease are expected to double by the year 2020. Every one of these conditions is painless and has no warning signs to the patient. The digital retinal photography examination can assist us in the early detection of these diseases and allow us to obtain a baseline to monitor your retinal health for comparison in the future.

We strongly recommend that all of our patients receive the retinal photography exam. It is especially important for people with:

(check all that apply)

- o Headaches
- o Spots or flashes in vision
- o A family history of glaucoma, macular degeneration, diabetes, or high blood pressure
- o High cholesterol
- o Circulatory problems
- o A strong eyeglass prescription (increases risk for retinal detachment)

There is an additional fee for this procedure of **$29.00.** If there is a diagnosis made, your insurance may help cover the cost. Please check the appropriate line below and sign the bottom.

____ I choose to have the digital retinal photography exam performed

____ I choose NOT to have the digital retinal photography exam performed

_____
Printed Name

_____ _____
Signature Date