BOSTON EYE PHYSICIANS AND SURGEONS

44 Washington Street Suite 103A Brookline MA 02445
Phone: (617) 232-9600 Fax: (617) 232-7002

Patient Information Form

Please bring completed form & Insurance card(s) to your appointment

Patient Name: _____ Gender: _____ DOB: _____

Address: _____

Cell Phone: _____ 2nd Phone: _____ Email: _____

Person responsible for bills (other than patient):

Patient Name: _____ Gender: _____ DOB: _____

Address: _____

Cell Phone: _____ 2nd Phone: _____ Email: _____

Emergency Contact:

Name: _____ Relationship: _____Cell Phone: _____

Insurance Information:

Primary Insurance Plan: _____

Name on the card: _____ ID Number: _____

Secondary Insurance Plan: _____

Name on the card: _____ ID Number: _____

How did you hear about us? _____

Primary Care Doctor or Referring Physician:

Doctor's Name: _____

Address: _____ Phone Number: _____

Patient Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Please complete this medical sheet. It will help your eye doctor to understand your general health to better treat your eye issues.

1. **Do you or have you had:**

Yes ☐	No ☐	Insulin Dependent Diabetes	Yes ☐	No ☐	Stomach Disease
Yes ☐	No ☐	Non-Insulin Dependent Diabetes	Yes ☐	No ☐	Thyroid Disease
Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐	Arthritis
Yes ☐	No ☐	Heart Attack	Yes ☐	No ☐	Gout
Yes ☐	No ☐	Cardiac Pacemaker	Yes ☐	No ☐	Liver Disease
Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Bleeding Disorder
Yes ☐	No ☐	Emphysema	Yes ☐	No ☐	Blood Clot
Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐	Anemia
Yes ☐	No ☐	Smoking History	Yes ☐	No ☐	Mental Illness
Yes ☐	No ☐	Cancer	Yes ☐	No ☐	AIDS / ARC / HIV Positive
Yes ☐	No ☐	Stroke	Yes ☐	No ☐	Syphilis
Yes ☐	No ☐	Neurological Disorder	Yes ☐	No ☐	Alcohol / Drug Abuse

2. **Have you had any eye diseases, eye surgery or eye injury?** **Yes** ☐ **No** ☐

   Please list: _____

3. **Do you use any eye drops or eye medications?** **Yes** ☐ **No** ☐

   Please list: _____

4. **Do you have a family history of glaucoma or macular degeneration?** **Yes** ☐ **No** ☐

   Please list: _____

5. **Have you had any major operations?** **Yes** ☐ **No** ☐

   Please list: _____

6. **Are you allergic to anything?** **Yes** ☐ **No** ☐

   Please list: _____

7. **Please list all the medications you are taking now with dosage**

   _____ _____ _____

   _____ _____ _____

   _____ _____ _____