FAMILY Vision CARE
OF MILFORD

WELCOME TO OUR OFFICE
PLEASE REGISTER

All information strictly confidential

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PERSONAL HISTORY (Please Print)

FORMAL PATIENT NAME: _____D.O.B._____ TODAY'S DATE:_____

STREET:_____ CITY & STATE:_____ ZIP_____

PHONE NO:_____WORK NO: _____ CELL NO: _____

PATIENT OCCUPATION and COMPANY:_____

PATIENT GRADE and SCHOOL (students only): _____

PERSONAL EYE HISTORY: Check and list **your** significant eye injuries, infections, diseases or conditions.

[ ] Cataracts [ ] Floaters [ ] Other:_____ [ ] None

[ ] Lazy eye [ ] Dry Eye _____ [ ] No Change

FAMILY EYE HISTORY: Check and list any significant diseases, conditions, or blindness of any member of your immediate family.

[ ] Cataracts [ ] Glaucoma [ ] Other: _____ [ ] None

[ ] Macular Degeneration _____ [ ] No Change

PERSONAL MEDICAL HISTORY: Check and list your significant medical diseases and conditions including all prescription medications and treatments. Use other side or attach separate sheet if necessary.

[ ] High Blood Pressure [ ] High Cholesterol: _____ [ ] None

[ ] Diabetes I, II [ ] Heart Disease [ ] Other: _____ [ ] No Change

ALLERGIES: Check and list all seasonal environmental and medical allergies.

[ ] Penicillin [ ] Sulfur _____ [ ] None

[ ] Pollen [ ] Other _____ [ ] No Change

SPECIAL NEEDS: Please detail any unique visual demands or requirements (ie: sports, hobbies, safety). [ ] None

_____ [ ] No Changes

WE ARE PROVIDERS FOR: MEDICARE, ANTHEM(most), CIGNA, HARVARD PILGRIM HEALTHCARE, HCVM, UHC(some), MVP, AND VISION SERVICE PLAN. **PLEASE PRESENT YOUR MEDICAL CARD PRIOR TO EXAMINATION. PATIENT ULTIMATELY ASSUMES RESPONSIBILITY FOR ELIGIBILITY AND PAYMENT.**

VISION CARE COVERAGE: YES [ ] NO [ ] Carrier: _____

POLICY HOLDER: Self [ ] Spouse [ ] Parent [ ] Formal Name: _____ D.O.B _____

PLEASE NOTE: PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. PLEASE SEE OUR BOOKKEEPER FOR ANY QUESTIONS YOU MAY HAVE REGARDING THIS MATTER.

FORM OF PAYMENT: (PLEASE CIRCLE) CASH CHECK CREDIT CARD DEBIT CARD

PLEASE RETURN THIS FORM TO OUR RECEPTIONIST. **THANK YOU**

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MEDICARE ONLY

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. Philip S. Aubrey for any services furnished me by Dr. Aubrey. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and/or its agents to determine these benefits or the benefits payable for related services.

Signature Date

Medicare Number