EASTON EYE CARE

Dr. Alan S. Bishop, O.D. ~~~ Dr. Alexander E. Carpenter, O.D.
Dr. Kyle N. Kravetz, O.D.

210 Marlboro Avenue, Suite 31 — Easton, Maryland 21601
402 Academy Street, Suite B — Cambridge, Maryland 21613
Phone: 410-822-EYES (3937)

Patient Registration Form

(Secure online form is located at www.eastoneyecare.net)

Please complete the information below and bring it when you come to our office. We understand that this form contains confidential information and we will handle with due diligence to protect your privacy.

Select a Practitioner:
__ Alan S. Bishop, O.D.
__ Alexander E. Carpenter, O.D.
__ Kyle N. Kravetz, O.D.

Select and Office Location:
__ Cambridge Office
__ Easton Office

Contact Information:

Name _____

Address _____ City _____ State ____ Zip _____

Home Telephone _____ Cell Telephone _____

Work Telephone _____ Other Telephone _____

Email Address _____

Personal Information:

Gender: ___ Female ___ Male

Date of Birth ___/___/___ Social Security _____-_____-_____

Marital Status: __Divorced __Legally Separated __Married __Single __ Widowed __Other

Employment Status:

__Employed Full-time __Employed Part-time __Not Employed __On Active Military Duty
__Retired __Self-Employed __Student Full-time __Student Part-time __Other

Patient Registration Form (Continued)

Employer _____

Occupation _____

How were you referred to our office?
__Friend or Family __Family Doctor __Ophthalmologist __Insurance Company __Internet
__Television __Radio __Received Mailing __Other Optometrist __Other

Eye History:
Please check off any current conditions you suffer from:
__Headaches
__Glare/Light Sensitivity
__Tired Eyes
__Amblyopia (lazy eye)
__Burning
__Dryness
__Watery Eyes
__Eye Pain and/or Soreness
__Foreign Body Sensation
__Infection of Eye or Lid
__Itching
__Mucous Discharge
__Drooping eyelid(s)
__Redness
__Sandy or Gritty Feeling
__Strabismus (crossed eye)
__Blurred Vision at Distance
__Blurred Vision at Near
__Haloes
__Double Vision
__Floaters or Spots
__Fluctuating Vision
__Loss of Vision
__Loss of Side Vision
__Flashes of Light

I stopped wearing glasses because: _____
_____

I stopped wearing contact lenses because: _____
_____

Glasses History: (Skip if you don't wear glasses)
What glasses do you own?
__Single Vision __Bifocals __Safety Glasses __Backup Glasses __Progressive __Trifocals
__Sports Glasses __Sunglasses __Other

How many hours a day do you use a computer? _____

How many inches away approximately do you sit from your computer monitor? _____

Please check off any current conditions you suffer from:
__I am having problems with my current glasses
__There are times when I would rather not be wearing glasses
__I have problems with night vision
__I am allergic to nickel (e.g. frames or glasses)
__I don't have a spare set of glasses
__My spare glasses have an incorrect prescription
__My sunglasses are missing UV (ultra-violet) protection

Contact Lens History: (Skip if you don't wear contacts)
What brand of contact lenses do you wear? _____

How often do you replace or dispose your contact lenses? _____

What is your typical wearing schedule? Hours/Days/Week _____

Please check off any current problems with your current contact lenses:
__There are times when I would rather not be wearing contact lenses
__I am interested in changing or enhancing my eye color
__I am interested in a non-surgical method of vision correction
__I am interested in refractive laser surgery
__I don't have a spare set of contact lenses
__My spare contact lenses have an incorrect prescription

Medical History:
When, approximately, was your last eye exam? _____

Where did you get your last eye exam? _____

When, approximately, was your last physical exam? _____

Who is your primary care physician? _____

Do you drink alcohol? __No __Yes, 1 per day __Yes, 2-3 per day __Yes, 4+ per day

Patient Registration Form (Continued)

Medical History: (continued)
Do you smoke? __No __Yes, ½ pack a day __Yes, 1 pack per day __Yes, 1+ pack(s) per day

Please list all medical conditions you have ever had (Diabetes, High Blood pressure, Arthritis, etc.)

Please list all eye diseases you have ever had (Glaucoma, Cataract, Wandering or Lazy eye, Retinal detachment)

Please list any medical or eye conditions that run in your family and the relationship of the family member (blood relatives). (Diabetes, High blood pressure, Cancer, Glaucoma, Macular degeneration, etc.)

Please list all hospital surgeries you have ever had:

Please list all prescription and over the counter medications you take and for what conditions:

Please list all drug allergies you have:

Please check off any current conditions you suffer from:
__Chronic fever, unexpected weight loss/gain, fatigue
__Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
__Heart problems (eg. Chest pain, irregular heartbeat, swelling of feet, cold hands/feet)
__Respiratory problems (eg. Shortness of breath, wheezing, coughing)
__Gastrointestinal problems (eg. Heartburn, abdominal pain, diarrhea, vomiting)
__Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)

Patient Registration Form (Continued)

Medical History: (continued)

__Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
__Skin problems (eg. Rashes, excessive dryness, growths or lumps)
__Neurological problems (eg. Numbness, weakness, headaches, “blackouts”)
__Psychiatric problems (eg. Depression, anxiety)
__Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
__Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
__Immune problems (eg. Frequent infections, allergic reactions to food, dust, pollens)

Primary Insurance or Discount Plan:

Please bring all medical and/or vision insurance cards with you to your appointment.
Insurance Company or Discount Plan Name

Insurance Company Address

Insured’s Name

Identification Number and Group Number

Insured’s Date of Birth

Insured’s Social Security Number

Patients Relation to Insured

HIPAA Privacy Policy – Health Information Protection

This policy is available on our website (www.eastoneyecare.net) and is located in our waiting area. Obtaining this signed document from you is a federal regulation. Thank You for your time and attention. We look forward to serving you and your family with high quality service and products.

Updated 11/20/2017