KITTERY OPHTHALMIC CONSULTANTS
NEW ENGLAND DRY EYE & AESTHETICS
NEW PATIENT FORM

Patient:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Primary Telephone #:_____ Cellular Telephone #_____

Male:_____ Female:_____ DOB:_____ Age:_____ Marital Status:_____

Email:_____

Social Security #:_____ Occupation:_____

Work Telephone#_____

Primary Insurance:_____ Policy:_____

Secondary Insurance:_____ Policy:_____

Policy Holder:_____

Is your visit covered under Workman's Compensation?_____

Emergency Contact:_____

Relationship to Patient:_____ Telephone# _____

Name:_____ Date:_____

Primary Care Doctor:_____

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Optometrist:_____ Last Exam:_____

Person Referring you:_____

Pharmacy:_____ Telephone #:_____

ALLERGIES Y/N : (Please list all medication and environmental including reaction)

_____

_____

Current Eye Medications: (Name / Dosage):

_____

_____

Current Medication and Supplements:

Name	Dosage	Frequency	By Mouth/Injection/other

Medical History

Do you or have you ever used Tobacco? Y/N if yes, when? How often_____

Do you use Alcohol Y/N? Amount & how often?_____

If your answer is "Yes" to a question, provide diagnosis and date of diagnosis:

Have you or do you currently use a Retina containing product……Yes No _____

Thyroid Problems..... Yes No _____

Seizures..... Yes No _____

Stroke ..... Yes No _____

Asthma ..... Yes No _____

C.O.P.D. ..... Yes No _____

Sleep Apnea ..... Yes No _____

Coronary Artery Disease ..... Yes No _____

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Congestive Heart Failure ..... Yes No _____
Chest Pain ..... Yes No _____
High Blood Pressure ..... Yes No _____
Elevated Cholesterol ..... Yes No _____
Heart Attack ..... Yes No _____
Implantable Devices (pacemaker, etc.) .... Yes No _____
Cardiac Arrhythmia ..... Yes No _____
Rheumatic Fever..... Yes No _____
Diabetes ..... Yes No _____
Liver Problems ..... Yes No _____
Stomach Problems..... Yes No _____
Irritable Bowel Syndrome ..... Yes No _____
Reflux (G.E.R.D.)..... Yes No _____
Kidney Problems ..... Yes No _____
Incontinence of Urine ..... Yes No _____
Genitourinary Problems ..... Yes No _____
Osteoporosis ..... Yes No _____
Back or Neck Problems ..... Yes No _____
Arthritis ..... Yes No _____
Skin Problems ..... Yes No _____
Anemia ..... Yes No _____
Blood Disorder ..... Yes No _____
M.R.S.A. / V.R.E. ..... Yes No _____
Tuberculosis ..... Yes No _____
Cdifficile ..... Yes No _____
Hepatitis ..... Yes No _____
HIV or AIDS ..... Yes No _____

STDs ..... Yes No _____
Depression ..... Yes No _____
Anxiety ..... Yes No _____
Eating Disorder ..... Yes No _____
Cancer..... Yes No _____
Acne (indicate if you have taken Accutane) Yes No_____
Other Medical Problems ..... Yes No _____
Hospitalizations ..... Yes No _____
Botox or Fillers ..... Yes No _____

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Surgical History (please list your previous surgeries from most recent to oldest)

Surgical Procedure	Date	Surgeon

Family History

Please indicate which of your relatives has had any of the following conditions (Father, Mother, Sister, Brother, grandfather, grandmother)

Aneurysms	Y / N _____	Bleeding tendencies	Y / N _____
Cancer	Y / N _____	Diabetes	Y / N _____
Heart problems	Y / N _____	Hypertension	Y / N _____
Stroke	Y / N _____	Mental illness	Y / N _____
Eye Disorder or Disease	Y / N _____		

Mother's Maiden Name: _____

Ocular History

Please check off that apply to you and provide a date of diagnosis and/or procedure along with treating physician's name.

____ Cataract Surgery_____
____ Retinal detachment_____
____ Glaucoma Surgery or treatment_____
____ Iritis_____
____ Uveitis_____
____ Color Blindness _____
____ Dry Eye Disease _____
____ Corneal Dystrophy (Fuch's, guttata)_____
____ Other (please explain) _____

Please use additional paper if necessary and attach medication list if available

Patient Signature: _____Date:_____

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PATIENT HIPPA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient Name:_____DOB:_____

Signature:_____Date:_____

If not signed by patient, please indicate relationship:_____

If you wish for us to discuss your personal health information with any friends or family members, please list below:

_____ _____

_____ _____