KITTERY OPHTHALMIC CONSULTANTS
NEW ENGLAND DRY EYE & AESTHETICS

Name:_____ Date:_____
Primary Care Doctor:_____
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 _____
Congestive Heart Failure ..... Yes No _____
Chest Pain ..... Yes No _____
High Blood Pressure ..... Yes No _____
Elevated Cholesterol ..... Yes No _____

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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	_____

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

Surgical Procedure	Date	Surgeon

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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:_____

PATIENT HIPPA CONSENT FORM

KITTERY OPHTHALMIC CONSULTANTS
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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:

_____ _____

_____ _____

KITTERY OPHTHALMIC CONSULTANTS
NEW ENGLAND DRY EYE & AESTHETICS
99 U.S. ROUTE ONE BYPASS, SUITE B
KITTERY, MAINE 03904
(207) 439-4958

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# _____