WELCOME TO MILFORD FRANKLIN EYE CENTER. WE ARE A REGIONAL CENTER OF EXCELLENCE IN EYE CARE

Patient Registration Form

Patient Information

Patient Information

Last Name:	First Name: M.I.:	Previous Name (if applicable)
Mailing Address:	Apt #	
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Primary Care Physician:	Date of Birth:	Sex: ❑ Male ❑ Female
Provider or Optometrist referring you here:	Marital Status:	Social Security Number:
Emergency Contact Name:	Relationship to Patient:	Emergency Contact Phone #:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No
Preferred Pharmacy Name & Location:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Injury

Policy Holder Name:	Policy Holder Address if different from patient:	Patient relationship to Policy Holder:	
Type of Accident (Circle One) Workers Comp. / Auto Accident / Private Ins	Insurance Company Name:	Injury Date:	Claim Number:

Consent and Authorization

I certify that I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I understand that I am responsible for all charges not covered by my insurance, including those charges resulting from my failure to obtain the necessary referral and or authorization from my primary care provider or referring physician when required. I permit a copy of this authorization to be used in place of the original. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MFEC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Notice of Privacy Practices: Acknowledgment of Receipt:

I acknowledge that I was provided with a copy or Milford Franklin Eye Center Notice of Privacy Practices and Use and Disclosure of Protected Information.

Printed name of responsible party or authorized official_____ Date _____

Milford- Franklin Eye Center
A better vision for your eyes

MEDICAL HISTORY FORM

Please complete all areas below

PRINT NAME:_____ **DATE:**_____

Who referred you to our practice?

☐ My Primary Care Physician/ Nurse Practitioner- List name: _____
☐ Another Physician- List name: _____
☐ My Optometrist- List name: _____
☐ A Family Member- List name: _____
☐ A Friend- List name: _____
☐ I found you on the web
☐ An Advertisement- List where: _____

OCULAR HISTORY:

Do you have any of these conditions? **FAMILY HISTORY:**

AMBLYOPIA (Lazy Eye)	**Y**	**N**	AMBLYOPIA (Lazy Eye)	**Y**	**N**
GLAUCOMA	**Y**	**N**	GLAUCOMA	**Y**	**N**
RETINAL DETACHMENT	**Y**	**N**	RETINAL DETACHMENT	**Y**	**N**
MACULAR DEGENERATION	**Y**	**N**	MACULAR DEGENERATION	**Y**	**N**
CATARACT	**Y**	**N**	CATARACT	**Y**	**N**
DRY EYES	**Y**	**N**	DRY EYES	**Y**	**N**
DIABETIC RETINOPATHY	**Y**	**N**	DIABETIC RETINOPATHY	**Y**	**N**
EYE INJURY/EYE SURGERY	**Y**	**N**	RETINAL DISEASE	**Y**	**N**

LIST ALL EYE SURGERIES:

_____

_____

LIST ALL OTHER SURGERIES:

_____

DATE OF LAST EYE EXAM:_____ **By Whom?**_____

IF APPLICABLE: PLEASE PROVIDE YOUR CONTACT LENS BRAND AND POWER (LISTED ON BOX- YOU MAY WANT TO GET THIS INFO FROM HOME IF YOU DON'T HAVE IT WHILE YOU ARE WAITING)

RIGHT EYE:_____

LEFT EYE:_____

LIST ANY PROBLEMS WITH CONTACT LENSES:_____

_____

SOCIAL HISTORY: Circle all that apply

SMOKING:	NEVER	CURRENT (no. packs a day)		FORMER	
DO YOU DRIVE?		YES		NO	
DO YOU LIVE AT HOME?		YES		NO	
DO YOU LIVE ALONE?		YES		NO WITH SPOUSE/ROOMATE NO AT NURSING HOME	
DO YOU DRINK ALCOHOL		YES		NO	
OCCUPATION?		UNEMPLOYED		YES	NO
IF YOUNGER THAN 18 DO YOU RECEIVE SPECIAL EDUCATION SERVICES?		YES		NO	

YOUR MEDICAL HISTORY			FAMILY MEDICAL HISTORY		
HIGH BLOOD PRESSURE	**Y**	**N**	HIGH BLOOD PRESSURE	**Y**	**N**
HEART PROBLEMS	**Y**	**N**	HEART PROBLEMS	**Y**	**N**
ARTHRITIS RA / OA	**Y**	**N**	ARTHRITIS	**Y**	**N**
LUNG PROBLEMS	**Y**	**N**	LUNG PROBLEMS	**Y**	**N**
STROKE	**Y**	**N**	STROKE	**Y**	**N**
THYROID PROBLEMS	**Y**	**N**	THYROID PROBLEMS	**Y**	**N**
CANCER	**Y**	**N**	CANCER	**Y**	**N**
ELEVATED CHOLESTEROL	**Y**	**N**	ELEVATED CHOLESTEROL	**Y**	**N**
DIABETES Type 1 OR 2	**Y**	**N**	DIABETES	**Y**	**N**
HOW MANY YEARS_____			MIGRAINES	**Y**	**N**
ASTHMA	**Y**	**N**	ASTHMA	**Y**	**N**
BLOOD DISORDERS	**Y**	**N**	BLOOD DISORDERS	**Y**	**N**
MIGRAINES	**Y**	**N**			
HIV/AIDS	**Y**	**N**			
HEPATITIS	**Y**	**N**			
PREGNANCY	**Y**	**N**			
PROBLEMS W ANESTHESIA	**Y**	**N**			

REVIEW OF SYSTEMS: ***DO YOU HAVE NOW, OR HAVE YOU HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS? (Circle all that apply)***

MUSCULOSKELETAL:	**MUSCLE PAIN**	**BACK PAIN**	**JOINT SWELLING**
ALLERGIC/IMMUNOLOGIC:	**HAY FEVER**	**HAIR LOSS**	**FACIAL REDNESS**
CONSTITUTIONAL:	**WEIGHT LOSS**	**FEVER**	**LOSS OF APPETITE**
EAR, NOSE AND THROAT:	**HEARING LOSS**	**HOARSENESS**	**RINGING IN EARS**
CARDIOVASCULAR:	**CHEST PAIN**	**PALPITATIONS**	**SHORTNESS OF BREATH WHEN SLEEPING FLAT**
RESPIRATORY:	**COUGH**	**WHEEZING**	**SHORTNESS OF BREATH**
GASTROINTESTINAL:	**BLOOD IN STOOL**	**DIARRHEA**	**STOMACH PAIN**
GENITOURINARY:	**PAIN WITH URINATION**	**BLOOD IN URINE**	**GENITAL DISCHARGE**
SKIN:	**SKIN ULCERS**	**SKIN RASH**	**LUMPS**
NEUROLOGY:	**SEIZURES**	**HEAD TREMORS**	**HEADACHES**
PSYCHIATRIC:	**ANXIETY**	**PANIC ATTACKS**	**CLAUSTROPHOBIA**
HEMATOLOGY/LYMPHATIC:	**EASY BLEEDING**	**EASY BRUISING**	

LIST ANY MEDICATION YOU ARE TAKING:	**DOSAGE**	**FREQUENCY**

ALLERGIES TO MEDICATIONS/REACTIONS TOMEDICATIONS: _____

_____

_____

Please provide your Pharmacy name and Address_____

SIGNATURE OF PATIENT/ REPRESENTATIVE: _____ DATE_____

WELCOME TO MILFORD FRANKLIN EYE CENTER

About your eye appointment today

Eye appointments are time consuming, more so when you will receive an in-depth eye examination second to none.
The average time for your eye visit today and as it was communicated to you over the confirmation phone calls will be at least 2 hours. Please make the proper arrangements if you are unable to budget this time for your eye visit.

You eye appointment will go through many in-depth steps: Registration and health screening. Insurance verification. Referral verification. Medical history taking. Technician or optometrist screening. Vision check. Pressure check. Refraction (the testing of the power of your eyes). Dilation if indicated (at least 45 minutes are needed for a good dilation). Testing. Browsing for frames and glasses if needed. Extensive examination by MD or Optometrist. Evaluation and discussion of your eye condition. Follow-up appointment scheduling and discharge. We will send your medication orders directly to your pharmacy if applicable. This extensive list is again time consuming.

If you are not comfortable driving after dilation, we recommend arranging a driver.

Our eye center as well as all others specialist centers accepts emergencies. This causes some uncertainty in eye appointments timing as emergencies do take priority. You would want to be seen immediately if you are the patient with an emergency. If you have time limitations or other commitments and you cannot budget enough time for your eye examination today, we strongly recommend you reschedule your appointment.

There are many ways to do an eye examination: The quick way and the correct way. We take pride in the quality of the care we provide and appreciate your understanding.

Please note: Our optical shop provides quality eyeglasses at great prices including blue filter lenses, Crizal anti-glare coating and Varilux progressive no-line bifocals. We also carry designer frame sunglasses. Feel free to take a look while you're waiting.

Our practice has experts in contact lenses fitting including colored contact lenses. Our contact prices are lower than other retailers and we ship your yearly contacts order for free.

Did you know that Medicare covers 80% of the cost of your eyeglasses after cataract surgery?

All eye surgeries are performed in our Cataract and Laser Surgery Center in Milford- A state- of-the-art surgery center and closer to home.

We also would like to remind everyone that one of the most effective ways we have to protect ourselves and others from illness is good personal hygiene. This means washing your hands, especially, but also your body. It means being careful not to cough or sneeze on others, and putting items such as tissues (that may have germs) into a bin. At Milford Franklin Eye Center we are committed to a clean environment for the health and safety of all.

To prepare for your visit, please make sure to bring a photo ID and your insurance cards. Both are required of all new patients. If you have an HMO or are on MassHealth, please request a PCP referral from your Primary Care Provider. Your insurance policies require this for your visit to be completed. Copays are due at check in, no exceptions.

Welcome again to our practice, we are grateful that you have chosen us to take care of your eyecare needs.