WOLFEBORO EYE ASSOCIATES
Wolfeboro Shopping Center·36 Center St, Suite 5·PO Box 1196·Wolfeboro Falls, NH 03896·(603)569-8500

Registration Form

Patient Information:

Full Name:_____

Date of Birth: _____ Gender:☐Male ☐Female ☐Other _____

Address: _____

State:_____ City: _____ Zip_____

Email Address:_____

Preferred Contact Method:☐Phone ☐Email ☐Text

Emergency Contact Name:

_____

Relationship:_____Phone Number:_____

Medical Insurance Information (We do NOT accept vision insurance.

Please provide your medical insurance only.)

Primary Medical Insurance Company: _____

Policy Number:_____

Subscriber Name:_____

Subscriber DOB: _____

Relationship to Patient:_____

The information provided is accurate to the best of my knowledge. Initials_____ Date _____

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Ocular History:

Date of Last Eye Exam: _____

Do you wear: ☐ Glasses ☐ Contact Lenses(if yes,type?)_____

Reason for Visit:_____

Symptoms (check all that apply): - ☐ Blurry vision ☐ Eye pain or discomfort ☐ Flashes or floaters - ☐ Redness or irritation ☐ Dry eyes Headaches ☐ Difficulty driving at night ☐ Other:_____

Have you ever been diagnosed with (check all that apply):

☐ Glaucoma ☐ Macular Degeneration ☐ Dry Eye Disease ☐ Eye Surgery (describe): _____ ☐ Other: _____

Family Ocular History (check all that apply): ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Disease ☐ Blindness ☐ Other:_____ Systemic

Systemic Medical History : Smoke: ☐ Current ☐ Never ☐ Former

Primary Care Physician:_____Pharmacy:

Current Medications:_____

Allergies (including medication or eye drop allergies): _____

Medical Conditions (check all that apply): ☐ Diabetes/Pre-diabetic ☐ High Blood Pressure ☐ Heart Disease ☐ Thyroid Disease ☐ Autoimmune Disease ☐ High Cholesterol ☐ Stroke ☐ Other: _____

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