Wolfeboro Eye Associates Registration Form

Patient Information

Full Name:_____**Date of Birth:** _____

Gender: ☐ Male ☐ Female ☐ Other _____

Address: _____ **City:** _____

State:_____ ***Zip***_____

Phone Number: _____ **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:_____

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 Medical History

Primary Care Physician:_____

Current Medications:_____

Allergies (including medication or eye drop allergies): _____

Medical Conditions (check all that apply): ☐ Diabetes ☐ High Blood Pressure

☐ Heart Disease ☐ Thyroid Disease ☐ Autoimmune Disease

☐ High Cholesterol ☐ Stroke ☐ Other: _____

Consent & Signature The information provided is accurate to the best of my knowledge.

Patient/Guardian Signature: _____ **Date** _____