RHODE EYELAND LLC
Jacqueline Boisvert, OD
74 Frenchtown Road
North Kingstown, RI 02852

Name: _____ DOB: _____

Primary Care Physician: _____ When was your last physical? _____

Pharmacy Name and Location: _____

Are you allergic to any medications, foods, latex, or dyes? _____

What medical conditions do you have? _____

_____

May we electronically import prescriptions from your pharmacy? Yes/No

What medications or supplements are you taking? _____

_____

Are there any other changes to your health? _____

_____

Please circle all that apply:

Poor Vision	Cough	Rash/Hives	Rapid Heartbeat
Eye Pain	Congestion	Changing Moles	Anemia
Tearing	Wheezing	Allergies	High Blood Pressure
Red eye	Shortness of breath	Hay Fever	Bleeding
Temporary vision loss	Headache	Arthritis	Thyroid Abnormalities
Fever/Chills	Jaw pain/Scalp tenderness	Joint Pain/Stiffness	Diabetes
Stuffy nose	Seizure	Upset Stomach	Insomnia
Ear ache	Stroke	Diarrhea	Urinary Frequency
Weight loss	Paralysis	Constipation	Burning on Urination
Dry mouth	Anxiety/ Depression	Incontinence	

Please indicate all that apply:

Allergic to Adhesives or Lidocaine?	Yes or No
Using Blood Thinners or Flomax?	Yes or No
Have a Pacemaker, Defibrillator, or Artificial heart valve?	Yes or No
Have you been exposed to or had Ebola or MRSA?	Yes or No
Pregnant or planning to become pregnant?	Yes or No
Are you pre-medicating for any upcoming surgeries?	Yes or No

Signature: _____ Date: _____

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Patient Name: _____ Patient DOB: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services rendered at time of service. I authorize the release of any information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment. I understand that Rhode Eyeland LLC will not resubmit a claim to an insurance company not disclosed at the time of appointment.

I am fully aware that I am responsible for any and all charges not covered by my insurance at today's visit. This includes, but is not limited to:

- History
- Eye Examination
- Refraction
- Contact Lens Examination
- Any Screenings – including, but not limited to:
    - Visual Acuity, Color Blindness, Amsler Grid, Pupillary Distance
- Any Testing – including, but not limited to:
    - Auto-Refraction, OCT Scanning, Fundus Photography, Visual Field Testing
- Any Procedures or Treatments – including, but not limited to:
    - Corneal Abrasions, Epilation, Punctal Plugs, Foreign Body Removal, Bandage or Therapeutic Contacts

Signature: _____ Date: _____

Relationship to patient: Self Parent Power of Attorney

____ I **HAVE** PROVIDED A COPY OF MY INSURANCE CARD Initials: _____

____ I **HAVE NOT** PROVIDED A COPY OF MY INSURANCE CARD Initials: _____