HAMEL EYE ASSOCIATES

PEABODY - REVERE

Patient Information Form

Name _____ Date of Exam _____
Address _____ Phone (Home) _____
City _____ ST____ Zip _____ (Cell) _____
Email Address _____
Date of Birth _____ Age ____ Occupation _____ SS# _____

Please check if you experience any of the following eye symptoms:

☐ Headaches ☐ Eye strain ☐ Spots/Floaters ☐ Gritty feeling in eyes ☐ Blurry Vision ☐ Light flashes

When was your last EYE exam? _____ Where was it? _____

How have you heard of us? ☐ I was a previous patient ☐ You are on my Insurance panel ☐ TV ☐ Radio ☐ Newspaper ☐ Facebook ☐ ValPak ☐ Drive By ☐ Reminder Call/Card ☐ Family/Friend ☐ Other _____

Do you currently wear glasses? ☐ Yes ☐ No
If Yes, do you wear them for ☐ Distance ☐ Near ☐ Constantly ☐ Occasionally
If No, have you ever worn glasses ? ☐ Yes ☐ No
Do you currently wear Contact Lenses? ☐ Yes ☐ No
What type/brand? _____
Are you taking any medications (including Birth Control and Vitamins) ? ☐ Yes ☐ No
If yes, please list _____
Do you have any Allergies ? ☐ Yes ☐ No If yes, to what _____
Do you Smoke? ☐Yes ☐No Do you drink Alcohol ? ☐Yes ☐No

Have you or any of your parents, brothers/sisters or grandparents had any of the following?

You	Family		You	Family	
☐	☐	Cataracts	☐	☐	Diabetes
☐	☐	Glaucoma	☐	☐	High blood pressure
☐	☐	Lazy eye	☐	☐	Asthma
☐	☐	Macular Degeneration	☐	☐	Other:_____

Health Insurance Plans (please check one):

☐ Blue Cross ☐ Harvard ☐ Network Health
☐ Tufts ☐ Aetna ☐ Neighborhood Health Plan
☐ Medicare ☐ HealthNet ☐ Mass Health
☐ CIGNA ☐ United Health ☐ Other _____

Vision Insurance Plans:

☐ EyeMed ☐ Cole Managed Vision
☐ Other _____

Our doctor strongly recommends a **Dilated Eye Exam**. In some cases this requires a 2nd visit. Drops are placed in the eyes to rule out certain eye diseases. You will have blurry vision up close, slight distance blur and light sensitive for a few hours. **[ADDITIONAL Fee may be required for this service]** This may be covered by your health insurance.
(A referral may be necessary. Check deductibles)
☐ YES, I would like a dilated exam in addition to my general eye exam. ☐ NO, I do not want a dilated exam.

Insurance Information: Insurance Name: _____ ID# _____

Insurance authorization & assignment (please read & sign)

I hereby authorize Dr. Hamel & Associates to furnish information to my insurance carrier concerning my illness and treatment.
I hereby assign to the physician all payments for medical services rendered to myself or my dependents.
I understand that I am responsible for obtaining a referral from my Primary Care doctor (if required by my insurance) before my exam in order to be covered for services. I will be responsible for any co-payments or amount not covered by insurance.

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read or received a copy of Dr. Paul V. Hamel & Associates Notice of Privacy Practices.

Signature _____ Date _____

Sept 2014

For office use only:
☐ Regular Eye Exam ☐ Contact Lens Exam ☐ Medically Oriented Exam