

NEW PATIENT REGISTRATION PACKET

TODAY'S DATE			YOUR PRIMARY CARE PROVIDER (PCP)		
Last Name	First	MI	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Is this your legal name? If not, what is? <input type="checkbox"/> Yes <input type="checkbox"/> No _____	
Mailing Address		Physical Address (if different)		City	State
Preferred Phone # (____) ____-____		Alternative Phone # (____) ____-____		Marital Status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Civil Union	
Date of Birth ____/____/____			Occupation	Employer	

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient	Phone Number
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PRIMARY INSURANCE INFORMATION

<input type="checkbox"/> I currently have medical insurance			<input type="checkbox"/> I currently do not have medical insurance		
Medical Insurance Name	Policy Number	Group Number			
Policy Holder's Name	Policy Holders Date of Birth ____/____/____	Policy Holder's Employer			

SECONDARY INSURANCE INFORMATION

<input type="checkbox"/> I currently have secondary medical insurance			<input type="checkbox"/> I currently do not have secondary medical insurance		
Medical Insurance Name	Policy Number	Group Number			
Policy Holder's Name	Policy Holders Date of Birth ____/____/____	Policy Holder's Employer			

ADDITIONAL INFORMATION

Race <input type="checkbox"/> African-American/Black <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Asian-American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Native American <input type="checkbox"/> Other _____		Primary Language if not English: _____
What is your current gender identity? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> MTF Transgender <input type="checkbox"/> FTM Transgender <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose		What is your preferred name? _____
How did you hear about us? (check all that apply) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Hospital <input type="checkbox"/> Family/Friend <input type="checkbox"/> Employer <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Facebook <input type="checkbox"/> Manchester Journal <input type="checkbox"/> Bennington Banner <input type="checkbox"/> Radio <input type="checkbox"/> Other _____		

322 Dewey Street
Bennington, VT 05201
Phone: (802) 447-8700
Fax: (802) 447-1500

5222 Main Street
Manchester Ctr., VT 05255
Phone: (802) 366-8050
Fax: (802) 366-8045

Doctors Building, Suite 110
North Adams, MA 01247
Phone: (413) 664-6736
Fax: (413) 644-7349

PERSONAL MEDICAL HISTORY

Conditions I have (check all the apply)

- Asthma Cancer Depression Diabetes Emphysema/COPD Heart Disease High Blood Pressure
 Skin AIDS/HIV Lymphatic Arthritis Other: _____

Medications-Please fill out or attach list

(include all prescriptions, over the counter, vitamins, minerals, supplements and herbal products)

Allergies and adverse food / drug reactions

Name of Medicine	Dose	Times per day	Food, Drug or Substance	Side effect / Reaction
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

No Current Medications

No Known Allergies

Briefly list all hospitalizations, major illnesses, and injuries, surgeries and dates:

Family History; Has any blood relative had any of the following? If yes, indicate the relationship to patient.

- | | | | | | |
|------------------------|--|-------|------------------------|--|-------|
| Blindness..... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | High blood pressure.. | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Cataract..... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | Heart disease/stroke.. | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Glaucoma..... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | Cancer..... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Macular Degeneration. | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | Arthritis..... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |
| Retinal Detachment.... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ | Diabetes..... | <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ |

Have you ever had any of the following eye conditions? If yes, please explain.

- Eye disease..... No Yes _____
 Eye injury..... No Yes _____
 Eye surgery/Lasik..... No Yes _____

Do you wear contacts..... No Yes Type: Daily Wear Extended Wear

What kind, power and base curve? _____

Do you wear eyeglasses..... No Yes Type: Distance Read Bifocals/Progressive

Do you smoke or use other tobacco products:

Yes no in the past

If so what: _____

Age you started: _____ If you have quit, age when you did: _____

Average packs/day during your Smoking: _____

Do you drink alcohol:

Yes no in the past

How many drinks per day? _____

Per week? _____

To the best of my knowledge, the preceding answers are true and correct:

Patient Signature

Date

Printed