ADVANCED EYECARE
Experienced people with vision

NEW PATIENT REGISTRATION PACKET

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

EMERGENCY CONTACT INFORMATION

Name	Relationship to Patient	Phone Number

PRIMARY INSURANCE INFORMATION

☐ I currently have medical insurance ☐ 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

☐ I currently have secondary medical insurance ☐ 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 ☐ African-American/Black ☐ Multi-Racial ☐ Asian-American ☐ Caucasian/White ☐ Native American ☐ Other_____

Primary Language if not English: _____

What is your current gender identity?
☐ Male ☐ Female ☐ MTF Transgender ☐ FTM Transgender ☐ Other ☐ Choose not to disclose

What is your preferred name? _____

How did you hear about us? (check all that apply)
☐ Dr._____ ☐ Hospital ☐ Family/Friend ☐ Employer ☐ Insurance Plan ☐ Facebook
☐ Manchester Journal ☐ Bennington Banner ☐ Radio ☐ 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)

Name of Medicine	Dose	Times per day

☐ **No Current Medications**

Allergies and adverse food / drug reactions

Food, Drug or Substance	Side effect / Reaction

☐ **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…….	☐No ☐Yes	_____	High blood pressure..	☐No ☐Yes	_____
Cataract……...	☐No ☐Yes	_____	Heart disease/stroke..	☐No ☐Yes	_____
Glaucoma……	☐No ☐Yes	_____	Cancer……...	☐No ☐Yes	_____
Macular Degeneration.	☐No ☐Yes	_____	Arthritis…….	☐No ☐Yes	_____
Retinal Detachment….	☐No ☐Yes	_____	Diabetes……	☐No ☐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