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office use only

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WELCOME TO OUR OFFICE

In order that we may serve you better, please complete the following information sheet for our records. This information will become part of your office records, and will be held in strict confidence.

MR. MRS. NAME: MS. MISS (CIRCLE ONE) FIRST MIDDLE INITIAL LAST

ADDRESS: \_\_\_\_\_

ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_

HOME PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

CELL PHONE \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE \_\_\_\_\_ EXT. \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

Person responsible for your account (if other than yourself)

Please list any insurance coverage which may apply to your visit.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Is this your first visit to this office? Y \_\_\_\_\_ N \_\_\_\_\_

If so, whom may we thank for referring you? \_\_\_\_\_

Professional fees for all services are payable at the time services are rendered. 50% of fees for contact lenses and eye-glasses are payable at the time they are ordered and the balance at the time they are dispensed.

Signature \_\_\_\_\_

Date \_\_\_\_\_

PLEASE CONTINUE ON OTHER SIDE

Business Correspondence P.O. Box 7487 Portland, Maine 04112 207/885-8686 fax 207/883-7154

152 Middle Street Portland, Maine 04101 207/773-2020 fax 207/775-2447

770 Congress Street Portland, Maine 04102 207/772-8384 fax 207/773-0020

256 U.S. Route One Falmouth, Maine 04105 207/781-5580 fax 207/781-2428

Ten Q Street South Portland, Maine 04106 207/799-3877 fax 207/799-4617

201 U.S. Route One Scarborough, Maine 04074 207/883-2809 fax 207/885-5607

# HEALTH SUMMARY

## EYE HEALTH

When was your last eye examination? \_\_\_\_\_

Who was your previous eye doctor? \_\_\_\_\_

Please circle any of the following disorders that you currently have or have had in the past.

Glaucoma	Crossed Eyes
Double Vision	Itchy Eyes
Eye Surgery	Eye Injuries
Light Flashes	Halos Around Lights
Tunnel Vision	Cataracts
“Floaters” - recent onset	Cataract Surgery
Amblyopia (lazy eye)	

Please circle any of the following disorders that a member of your immediate family currently has or has had in the past.

Diabetes	High Blood Pressure
Blindness	Glaucoma
Eye Disease	

Have you ever had problems adjusting to a pair of eyeglasses?	Yes	No
Have you ever worn contact lenses?	Yes	No
If not, have you ever considered contact lenses?	Yes	No
Do you work or participate in any sports where there is an eye hazard?	Yes	No

## GENERAL HEALTH

Who is your primary (family) physician? \_\_\_\_\_

When was your last physical examination? \_\_\_\_\_

Please circle Yes or No

Do you have any allergies, including drug allergies?	Yes	No
If so, please list _____		

Do you have sinus trouble?	Yes	No
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Do you have frequent headaches?	Yes	No
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Are you currently under a physician’s care?	Yes	No
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If yes, for what reason? \_\_\_\_\_

Are you presently taking any medications?	Yes	No
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If so, please list (include birth control pills) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please circle any of the following disorders that you currently have or have had in the past.

Heart Trouble	High Blood Pressure
Blood Vessel Disease	Thyroid Problem
Asthma	Epilepsy
Diabetes	Anemia

What is the main purpose for your visit today? \_\_\_\_\_

**Thank you for the opportunity to provide vision care for you and your family.**