



PATIENT INFORMATION

Today's Date:
Name: Nickname: Gender:
Date of birth: Patient SSN:
Mailing Address:
Phone Number: Cell Phone:
Email: Preferred method of communication:
Preferred Language: Race: Ethnicity:
Primary Care Physician Name:
Preferred Pharmacy: Pharmacy Phone Number:
Parent/Guardian Name:
Emergency Contact Name/Phone Number:
Please circle reason for visit: Routine Examination Contact Lens Examination Emergency Other
Who may we thank for referring you to us?
Did another doctor refer you to us?

INSURANCE INFORMATION

Medical Insurance: Name of Insured:
ID #: Relationship of Insured:
Secondary Insurance: Name of Insured:
ID #: Relationship of Insured:
Vision Insurance: Name of Insured:
ID #: Relationship of Insured: DOB:

AUTHORIZATIONS

I authorize Puzio Eye Care to leave a message with any important health information YES or NO
I authorize Puzio Eye Care to release any medical information to providers who request it YES or NO
I authorize Puzio Eye Care to disclose my past, present and future protected health information, including contact lenses, glasses and copies to prescriptions to the following people:

The Dr. may recommend a dilated eye exam to fully assess eye health. With dilation, drops are placed in the eyes to enlarge the pupils so that the Dr. can examine the eyes for any diseases. I authorize Puzio Eye Care to dilate my child's eyes today. YES or NO

PRIVACY PRACTICES for HEALTH INFORMATION

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductible, co-insurances/or amounts for services not covered by my insurance carrier. If my insurance is a managed care plan requiring a referral from my Primary Care Provider (PCP), I understand that if I do not obtain this referral or if my PCP will not provide one, I will be responsible for any and all charges incurred during my treatment.

I acknowledge that I was offered a copy of the Notice of Privacy Practices at Puzio Eye Care Associates.

I/we hereby authorize Puzio Eye Care to administer procedures as may be necessary for proper health care.

I understand that the InfantSEE vision assessment is without charge. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

Patient/Guardian Signature: Print Name: Date:

Matthew S. Puzio, O.D.

Elizabeth T. Potvin, O.D.

Matthew J. Philibin, O.D.

HARWICH DENNIS

119B Route 137
860 Route 134, Unit 8

P.O. Box 1661
P.O. Box 1412

East Harwich, MA 02645
South Dennis, MA 02660

508.432.3444
508.394.2211

508.432.3401 fax
508.398.4471 fax

PATIENT HISTORY

Today's Date: _____ Name: _____ Date of birth: _____

What brings you in to our office today? _____

Date of last eye examination: _____ Date of last medical examination: _____

Previous Eye Doctor: _____ Primary Care Doctor: _____

Does your child (check all that apply):

- wear prescription glasses wear prescription sunglasses
- wear contact lenses Brand of contacts: _____
- have "back up" glasses have sports/safety eyewear

What are any specific problems that your child has with their vision, eyes, glasses or contact lenses?

How long has the problem been observed? _____

Would you like a contact lens evaluation today? YES NO MAYBE

Would you like to meet with an optician about glasses today? YES NO MAYBE

LIFESTYLE INFORMATION

What are your child's hobbies _____

School Name: _____ Grade: _____

Has your child had extra help or tutoring in school?

How would you describe your child's reading ability?

Does your child often lose their place when reading?

How much screen time does your child get during an average week?

FAMILY MEDICAL/EYE HISTORY

Have any family members been diagnosed with any of the following? Which family member?

- Blindness _____ Retinal Problems _____
- Cataracts _____ Macular Degeneration _____
- Glaucoma _____ Diabetes _____
- Eye Tumor _____ Lazy Eye _____
- Eye Turn _____ Other _____

What are the parents history with eyeglasses?

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PATIENT EYE HISTORY

Has your child experienced any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Pain/Irritation/Itch/Swelling |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Severe sensitivity to light |
| <input type="checkbox"/> Misreads words/Letter reversals | <input type="checkbox"/> Flashes/Floaters/Spots |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> White appearance in pupil |
| <input type="checkbox"/> Eye fatigue/Tired eyes | <input type="checkbox"/> Eye injury/Trauma/Abrasion |
| <input type="checkbox"/> Eye turn/Crossed eyes | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Lazy eye/ Amblyopia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Color Blindness | |

PATIENT MEDICAL HISTORY

Has your child ever been diagnosed or treated for problems relating to the following:

- | | |
|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Digestive | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Heart attack/Stroke |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Diabetes/Endocrine |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Muscle/Bone Arthritis | <input type="checkbox"/> Reproductive |
| <input type="checkbox"/> Respiratory/Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Immune system | <input type="checkbox"/> STD |
| <input type="checkbox"/> Other health problems _____ | |

Did your child have a premature birth? At how many weeks?

Any complications during pregnancy?

Any complications during delivery?

Has your child shown normal development?

Has your child had physical/developmental therapy?

Has your child had any surgeries?

Do you have any allergies to medications: _____

Please list current medication including eye drops and over - the - counter:

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