Mashpee Vision Care

681 Falmouth Road, Upper Level
Mashpee, MA 02649
508-477-1802

Welcome to the office of Dr. Nyssa d'Hedouville, Doctor of Optometry
Please complete this two-page medical history form. It will enable us to better assist you with your eye care needs.

Name: _____ Birth Date: _____

Address: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Insurance: _____ Vision Insurance: _____

Subscriber: _____ /DOB: _____ Occupation: _____

Employer: _____ Address: _____

Patient's relationship to subscriber: Self Spouse Former Spouse Domestic Partner Child Other

Race: American Indian or Alaska Native/Asian/Black or African American/Hispanic/Native Hawaiian or other Pacific Islander/White

Gender: M F **Ethnicity:** Hispanic or Latino/native Hawaiian or Other Pacific Islander/Not Hispanic or Latino

Primary Care Physician: _____ Date Last Seen: _____

Preferred method of communication: Email Telephone Postal

How did you hear about our office, we would like to thank them: _____

Assignment and Release

I authorize payment of benefits directly to Dr. Nyssa d'Hedouville for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand that some services may require approval of my primary care physician for coverage and that, if I do not obtain that approval/referral, I am financially liable for the services. I understand that my insurance carrier may not cover some services or products, and that benefits information does not constitute approval of payment. I understand that it is my responsibility to understand the benefits, services, and products covered by my individual policy. Deductible and Fees not paid by my insurance carrier will be my responsibility.

Signature: _____ Date: _____

Acknowledgement of receipt of Notice of Privacy Practices

My signature below verifies that I have received a copy of the Mashpee Vision Care Notice of Privacy Practices for Mashpee Vision Care.

Name of Patient: (print) _____ Signature of Patient: _____ Date: _____

Signature of Patient Representative (if patient is a minor or an adult unable to sign this form)

Relationship of Representative to Patient _____

Permission to Share Medical Information

My medical information may be obtained and exchanged verbally to:

_____ _____
Name/Relationship Initials of patient/guardian

Permission to Bill Your Insurance

All professional services rendered are charges to the patient. Necessary forms will be completed by the office of Mashpee Vision Care to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes releasing of the information to the insurer or agency given to Mashpee Vision Care for participating health insurance plans.

_____ _____
Signature of patient/guardian Date

Patient Health History

Medical/Family History

Please list all your current medications (including over the counter, vitamins and herbal therapy): _____

_____

List all major surgeries (Eye Surgery Included): _____

List any allergic reactions to medication or eye drops: _____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition	Yourself				
	Yes	No		Yes	No
Cataract	☐	☐	Women-Are you pregnant?	☐	☐
Eye Turn/Lazy Eye	☐	☐	Are you breast feeding?	☐	☐
Glaucoma	☐	☐			
Macular Degeneration	☐	☐			
Retinal Detachment	☐	☐			

	Family Member		Relationship (Blood Relatives only)				
	Yes	No			Yes	No	
Blindness	☐	☐	_____	Arthritis	☐	☐	_____
Eye Turn/Lazy Eye	☐	☐	_____	Cancer	☐	☐	_____
Glaucoma	☐	☐	_____	Diabetes	☐	☐	_____
Macular Degeneration	☐	☐	_____	Heart Disease	☐	☐	_____
Retinal Detachment	☐	☐	_____	Kidney Disease	☐	☐	_____
				Thyroid Disease	☐	☐	_____

Other: _____

Review of Systems Please indicate below if you have or ever had problems with he following conditions:

Allergic/Immunologic
- ☐ None
- ☐ Lupus (SLE)
- ☐ Rheumatoid Arthritis
- ☐ Environmental Allergies
- ☐ Seasonal Allergies
- ☐ Other (i.e., Latex)

Ear, Nose and Throat
- ☐ None
- ☐ Sinusitis
- ☐ Upper Respiratory Tract Infection
- ☐ Other

Gastrointestinal
- ☐ None
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Acid Reflux/Ulcer
- ☐ Other

Skin/Integumentary
- ☐ None
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Other

Psychiatric
- ☐ None
- ☐ Depression
- ☐ Bi-Polar
- ☐ Schizophrenia
- ☐ Other

Cardiovascular
- ☐ None
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Vascular Disease
- ☐ High Blood Cholesterol

Endocrine/Glands
- ☐ None
- ☐ Diabetes
- ☐ Hormone Dysfunction
- ☐ Thyroid Dysfunction
- ☐ Other

Respiratory
- ☐ None
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other

Muscle/Skeletal
- ☐ None
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Other

Genital/Urinary
- ☐ None
- ☐ Urinary Tract Infection
- ☐ HIV Positive
- ☐ Herpes/Chlamydia
- ☐ Other

Hematologic/Lymphatic
- ☐ None
- ☐ Anemia
- ☐ Leukemia
- ☐ Bleeding Disorder
- ☐ Other

Neurological
- ☐ None
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Tremors
- ☐ Other

General Health
- ☐ None
- ☐ Weight Loss/Gain
- ☐ Fever
- ☐ Fatigue
- ☐ Cancer

Social

Tobacco Use ☐ Never ☐ Former Smoker

☐ Current Smoker

☐ Non-Prescription Drugs _____

☐ Alcohol Consumption _____

Weight: _____ Height: _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's Initials: _____

Thank you for completing our medical history form. Each Time you visit the office, you will be asked to review this Information. Please make changes directly on the form, then date and initial on the lines below.

_____	_____	_____	_____	_____	_____	_____
Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date	Initials/Date