

DR. PAUL V. HAMEL & ASSOCIATES

REVERE - PEABODY - STONEHAM

Patient Information Form

Name _____ Date of Exam _____
Address _____ Phone (H) _____
City _____ ST _____ Zip _____ (W) _____
Email Address _____
Date of Birth _____ Age _____ Occupation _____ SS# _____
What is the main reason for your exam today? (ex. Decreased distance vision, contact lens fit, Red Eye treatment)

When was your last EYE exam? _____ Where was it? _____

Do you currently wear glasses? Yes No
If Yes, do you wear them for Distance Near Constantly Occasionally
If No, have you ever worn glasses? Yes No
Do you currently wear Contact Lenses? Yes No
What type? _____
Are you taking any medications (including Birth Control and Vitamins)? Yes No
If yes, please list _____
Do you have any Allergies? Yes No
If yes, to what _____

Please check if you experience any of the following eye symptoms:

Headaches Eye strain Spots/Floaters Gritty feeling in eyes Itchy Eyes Light flashes
Have you or any of your parents, brothers/sisters or grandparents had any of the following?

You	Family		You	Family	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Health Insurance Plans:

Blue Cross Harvard Network Health
 Tufts Aetna Neighborhood Health Plan
 Medicare HealthNet Mass Health
 CIGNA United Health Other _____

Vision Insurance Plans:

EyeMed VSP Vision One
 Cole Managed Vision ECPA
 Other _____

An Optomap Retinal Image completes a **Comprehensive Eye Exam** and is highly recommended.
A quick and easy photo is taken of the back of your eye providing us with information similar to a dilated exam
BUT without the eye drops, blurry vision and light sensitivity afterwards.
[**ADDITIONAL \$35 Fee for this service – not covered by Insurances**]

YES, I would like a retinal image in addition to my general eye exam. NO, I do not want a comprehensive exam.

Insurance Information: Insurance Name: _____ ID# _____

Insurance authorization & assignment (please read & sign)

I hereby authorize Dr. Paul V. Hamel & Associates to furnish information to my insurance concerning my illness & treatment.
I hereby assign to the physician all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for obtaining a referral from my Primary Care doctor (if required by my insurance) before my exam in order to be covered for services. I will be responsible for any co-payments or amount not covered by insurance.

Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have read or received a copy of the office's Notice of Privacy Practices.

Signature _____ Date _____