535 Saybrook Road Middletown, CT 06457 Tel: (860)347-9377 Fax: (860) 347-4146
7 wildwood Medical Center Essex, CT 06426 Tel: 860 767-0184 Fax: 860 767-7724

For Office use only **prior auth**_____ **INS**_____
Copay $_____**check/cash/card**
Eligible YES [ ] NO [ ] # _____

DOS:_____ **Time:**_____ **Exam Type:** _____ **Acct#** _____

Dr. Beggins/ Dr Kelleman / Dr Murphy / Dr Salierno

Patients Name _____ **Sex:**MALE/FEMALE **D/O/B:** _____

Please Circle: *This information is requested due to Healthcare Reform laws dictated by Congress.*
Race: American Indian Asian Black Multi-racial Native Hawaiian White
Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino
Preferred Language: English __ Spanish __Other: _____ Occupation: _____

Home Address: _____ City: _____ State:_____Zip:_____

Home Phone #: _____Work Phone #:_____ Cell Phone #:_____

Reason for Visit: _____**Primary Care Physician:**_____

Email address: _____ Social Security: _____
(To access your medical records on our web portal please provide your email address and social security number)

Emergency Contact: _____Phone: _____Relationship: _____

Guardian Name_____Phone:_____Relationship:_____

Who referred you to CT EYE PHYSICIANS? _____

Is this a work related injury? Yes____No____ Injury detail _____

Medical History: Do you have any of the following? If yes please check.
[ ] Asthma [ ] Cancer [ ] Migraines [ ] Neurological Condition
[ ] Kidney Disease [ ] **Diabetes Type 1** [ ] High Cholesterol [ ] Psychiatric Condition
[ ] GI Condition [ ] **Diabetes Type 2** [ ] Arthritis [ ] Thyroid Disease
[ ] Skin Disease [ ] Heart Disease [ ] High Blood Pressure
[ ] Tuberculosis **[ ] Pregnant/ Nursing** [ ] **Other** _____ [ ] **Pacemaker**
[ ] **Have you ever been diagnosed with the following eye condition? If yes, check**
[ ] Cataract [ ] Glaucoma [ ] Macular Degeneration [ ] Retinal Detachment/Tear
[ ] Diabetic eye disease [ ] Lazy eye
[ ] Other

_____
Please List past surgeries (including eye):

_____
Please List all Drug Allergies: _____
Do any medical or eye diseases run in your family? (i.e. diabetes, cancer, macular degeneration)
Please List: _____
Do you smoke? Y [ ] N [ ] if yes, how much? _____ pks/day if quit how many years ago?
Do you drink alcohol? Y [ ] N [ ] if yes, how often? [ ] 1-2 per week [ ] 3-7 per week [ ] >7 per week

****PLEASE TURN PAGE OVER TO LIST MEDICATIONS (including eye) AND WHAT CONDITIONS YOU ARE USING THEM FOR****