Welcome to **Blondin Shea Eyecare** www.blondinsheaeye.com

Matthew Blondin, O.D., F.A.A.O. • Michael Shea, O.D.

Find us on: Facebook, Health Grades & Yelp

Patient Full Name: ______________________________
Nombre completeo del paciente

Gender Male: _____ Female: _____
Sexo Hombre Mujer

Street Address: ______________________________
Dirección de la calle

____

City: ________________ State: ____ Zipcode: ________
Ciudad Estado Código Postal

Home Phone: ______________ Cell: ______________
Teléfono de Casa Teléfono Celular

Date of Birth: _____ /_____ /_____
Día de nacimiento

Social Security Number: ________________
Número de Seguro Social

Insurance Company: ______________________________
Compañía aseguradora (Husky, Medicare, Blue Cross, Aetna, Connecticare, United Health Care, Etc.)

Insurance ID Number: ______________________________
Número de identificación del seguro

Email Address: ______________________________
Dirección del correo electrónico

Primary Care Doctor: ______________________________
Médico de Atención Primaria

How did you hear about our practice? (New Patients Only)

___ Friend/Family ____ *Amigo / Familia*
___ Search engine/Website ____ *Motor de búsqueda / sitio web*
___ Social Media ____ *Medios de comunicación social*
___ Billboard ____ *Cartelera*
___ Other ________________ ____ *Otro*________________

If patient is a minor, parent or legal guardian:
Si el paciente es menor de edad, el padre o tutor legal

Name :____________________ Phone: ________________
Nombre Teléfono

Attention: Please take note: By signing below I am indicating my understanding of this office's privacy practices which are available upon request. Also I give permission to the Doctors in the office to obtain data from my pharmacy electronically. I understand that if my primary insurance carrier does not pay all charges in full, I will be responsible for the remaining balance due to Blondin Shea Eyecare. If we cannot verify your insurance coverage, your appointment will be rescheduled. There is no refund on prescription eyewear. All prescription eyewear not picked up within 90 days of ordering will be donated to charity for those in need. Any patient who has not been present at time of a scheduled appointment on more then three occasions will be scheduled on a standby scheduled and may have an extended wait for appointments. (Traducción español disponible)

Signature: ______________________________ Date: ________

Do you smoke cigerettes? ☐ *Yes* ☐ *No*

How many per day? ________________

¿Fumas cigarrillos? ¿Cuántos por día?

Have you ever had any eye diseases or injuries? ☐ *Yes* ☐ *No*

Had tenido alguna enfermedad or accidente, Si o No?

*Please Describe:*____________________

Por favor describa:

Does anyone in your family have glaucoma, cataracts or macular degeneration?

¿Alguien en su familia tiene glaucoma, cataratas o degeneración macular? Si o No? ☐ *Yes* ☐ *No*

Who? *¿Quien?*____________________

Are you pregnant? ☐ Yes ☐ No

Estás embarazada?

Do you take any prescription medicines?

Estas tomando algun tipo de medicina, Si o No? ☐ Yes ☐ No

Please list:____________________

Por Favor Liste:

____

____

Health problems? ____________________

Problemas De Salud?

____

____

Are you allergic to any medicines?

Usted es Alergicos Algun Tipo de Medicina, Si o No?

☐ Yes ☐ No ____________________

Do you wear....?

Glasses: ☐ Yes ☐ No **Contacts**: ☐ Yes ☐ No
Lentes, Si o No? Contactos, Si o No?

When?¿Cuando?____________________

In the last year, have you had any of these symptoms?

En el último año, ¿ha tenido alguno de estos síntomas?

___Fluctuation In vision ___ *Cambio de vision*
___Contact discomfort ___ *Descomformidad de contactos*
___Tired Eyes ___ *Ojos cansados*
___Burning ___ *Quemasón*
___Feeling of sand in eye ___ *Siente que tiene arena en los ojos*
___Light Sensitivity ___ Sensitividad en La luz
___Watery Eyes ___ *Lagrimas en sus ojos*
___Redness ___ *Ojos Rojos*
___Itching ___ *Picason*
___ Other __________ ___ *Otro*______________

Please provide: **Height:** _____ **Weight:** _____