

MASHPEE VISION CARE
 681 FALMOUTH ROAD, UNIT B-12
 MASHPEE, MA 02649
 508-477-1802

Welcome to the office of Dr. B. Lynne Grove, Doctor of Optometry.
 Please complete this two-page form, so that we can better assist you with your eye care needs.

Name: _____	Birth Date: _____
Address: _____	Email: _____
Home Phone: _____ Work Phone: _____	Cell Phone: _____
Medical Insurance: _____	Vision Insurance: _____
Subscriber: _____ ID or SS#: _____	Occupation: _____
Employer: _____	Address: _____
Patient's relationship to subscriber: Self Spouse Former Spouse	Domestic Partner Child Other
How did you hear about our office, we would like to thank them: _____	

ASSIGNMENT AND RELEASE

I authorize payment of benefits directly to Dr. B. Lynne Grove 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, I am financially liable for 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. Deductibles and Fees not paid by my insurance carrier will be my responsibility.

Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

FAMILY/PERSONAL HISTORY- Please review the questions below, and mark all answers that apply.
 What Problems have you experienced, or are you currently experiencing with your eyes?

- | | | |
|------------------------|------------------------------|----------------------------|
| Blurred Vision | Redness | Mucous Discharge |
| Distorted Vision/Halos | Burning | Foreign Body Sensation |
| Loss of Side Vision | Itching | Sandy or Gritty Feeling |
| Loss of Central Vision | Dryness | Chronic Eye/Lid Infections |
| Double Vision | Tired Eyes | Sties or Chalazions |
| Flashes | Excessive Tearing/Watering | Eye Pain or Soreness |
| Floating Spots | Problems with Contact Lenses | Crusting on Eyelashes |
| Blindness | Crossed Eyes | Glare/Light Sensitivity |
| Retinal Detachment | Diabetic Eye Diseases | Cataracts |
| Macular Degeneration | Glaucoma | Lazy Eye |
| Retinal Disease | | |

Do any blood relatives have any of the following eye or medical conditions? What is their relationship to you?

	Relationship		Relationship
Arthritis	_____	Blindness	_____
Cancer	_____	Cataracts	_____
Diabetes	_____	Crossed Eyes	_____
Heart Disease	_____	Glaucoma	_____
High Blood Pressure	_____	Macular Degeneration	_____
Kidney Disease	_____	Retinal Detachment	_____
Thyroid Disease	_____	Retinal Disease	_____
Amblyopia (Lazy Eye)	_____	Other Conditions:	_____

