Dr. Paul K. Albert, O.D
125 Oak Street
Ellsworth, ME 04605

(P) 207-667-4237
(F) 207-667-0390
dralbertod@ne.twcbc.com

Demographics

☐Mr. ☐ Miss ☐Mrs. ☐Ms. ☐Male ☐ Female

_____ ____ _____ _____
First Name MI **Last Name** Preferred Name

_____
Street Address City State Zip

_____ ____/____/____ (___)_____ (___)_____ (___)_____
Social Security Number Date of Birth Home Phone Cell Phone Day Phone

_____ _____ _____
Email Address Guardian Person Responsible for Account

_____ _____
Emergency Contact Emergency Phone

How were you referred to our office? Who were you referred by?

☐Phone book ☐School ☐Advertisement ☐Patient _____
☐Insurance Listing ☐Drive by ☐Other ☐Doctor _____

PRIMARY INSURANCE INFORMATION

_____ _____ _____
Name and Address of Primary Insurance Company City State Zip

☐M ☐F _____ ____ _____
Insured's First Name MI Insured's Last Name

_____ _____ ____/____/____
Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured **Patient Status** ☐Single ☐Married ☐Other
☐Self ☐Spouse ☐Child ☐Other ☐Full Time Student ☐Part Time Student ☐Employed

Please Read:

I assign of all my medical benefits to Paul K. Albert, O.D. and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 120 days-old are subject to collections, and there will be a service charge of $15 for any bounced checks. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time that they are rendered. All Self-pay patients agree to pay in full on the day services are rendered.

_____ ____/____/____
Signature Date

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Patient History and Information

Race

☐American Indian ☐ Native Hawaiian ☐Asian ☐Black or African America ☐White
☐Hispanic or Latino ☐ Decline to Specify ☐ Other Race _____

Ethnicity ◯Hispanic or Latino ◯ Not Hispanic or Latino ◯ Declined to answer

Preferred Language ◯English ◯French ◯Spanish ◯Other_____

Primary Care Physician

_____

Primary Care Physician and Clinic Name

_____

Address of Primary Care Physician City State Zip Phone

Health History

Past Illnesses or Injuries: _____

_____

Past Surgeries: _____

_____

Current Eye Drops: _____

Current Medications _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: _____

Family History

Blindness	◯ Yes ◯No	Cataracts	◯ Yes ◯No	Eye Tumors	◯ Yes ◯No
Retinal Detachment	◯ Yes ◯No	High Blood Pressure	◯ Yes ◯No	Macular Degeneration	◯ Yes ◯No
Kidney Disease	◯ Yes ◯No	Lupus	◯ Yes ◯No	Thyroid Disease	◯ Yes ◯No
Color Blindness	◯ Yes ◯No	Cancer	◯ Yes ◯No	Diabetes	◯ Yes ◯No
Stroke	◯ Yes ◯No	Glaucoma	◯ Yes ◯No		

General Health Condition

Weight Loss	◯ Yes ◯No	pregnant	◯ Yes ◯No	Cholesterol (Blood/lymph)	◯ Yes ◯No
Anxiety, Depression	◯ Yes ◯No	Respiratory(asthma)	◯ Yes ◯No	Cardiovascular(heart/	
Thyroid	◯ Yes ◯No	Diabetes	◯ Yes ◯No	high blood pressure)	◯ Yes ◯No
Other	◯ Yes ◯No _____				

Eye History

Glaucoma	◯ Yes ◯No	Fluctuating Vision	◯ Yes ◯No	Excess Tearing/Watering	◯ Yes ◯No
Loss of Vision	◯ Yes ◯No	Glare/Light Sensitivity	◯ Yes ◯No	Color Blindness	◯ Yes ◯No
Strabismus(Crossed Eyes)	◯ Yes ◯No	Amblyopia (Lazy Eye)	◯ Yes ◯No	Floaters or spots	◯ Yes ◯No
Cataract	◯ Yes ◯No	Redness	◯ Yes ◯No	Vitreous Detachment	◯ Yes ◯No
Loss of Side Vision	◯ Yes ◯No	Headache	◯ Yes ◯No	Diabetic Retinopathy	◯ Yes ◯No
Blurred Vision Distance	◯ Yes ◯No	Dry Eye Syndrome	◯ Yes ◯No	Retinal Detachment	◯ Yes ◯No
Macular Degeneration	◯ Yes ◯No	Eye Injuries	◯ Yes ◯No	Double Vision	◯ Yes ◯No
Eye Pain or Soreness	◯ Yes ◯No	Blepharitis	◯ Yes ◯No	Loss of Central Vision	◯ Yes ◯No
Distorted Vision Near	◯ Yes ◯No	Glaucoma Suspect	◯ Yes ◯No	Infection of Eye or Lid	◯ Yes ◯No

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Medical History Questionnaire

Social History

Current Occupation: _____ Employer _____

Spectacle Lens History

Do you use a computer? ◯Yes ◯No How hours/days? _____ Distance from Computer? _____
Do you drive? ◯Yes ◯No Do you have glare problems? ◯Yes ◯No
Do you have visual difficulty when driving? ◯Yes ◯No
Do you have problems with night vision? ◯Yes ◯No
Do you currently wear glasses? ◯Yes ◯No Since_____
Type of glasses ☐ Fulltime ☐Part time ☐Distance ☐Near
Glasses Owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐Progressive
Have you had trouble in the past with glasses? ◯Yes ◯No _____
Do you wear sunglasses? ◯Yes ◯No Are your sunglasses your current prescription? ◯Yes ◯No

Contact Lens History

If not a contact lens wearer, are you interested in trying contacts lenses at this time? ◯Yes ◯No
Have you ever tried to wear contact lenses? ◯Yes ◯No Reason for stopping? _____
Do you currently wear contact lenses? ◯Yes ◯No Since _____
Type and Brand of contact Lenses _____ Today's wearing time? _____
How many hours/day? _____ How many days/week? _____

Social History

Do you drink alcohol? ◯Yes ◯No If yes, how much/ often: ◯Occasional ◯1 Per Day ◯2-3/day ◯4+/Day
Do you smoke? ◯Yes ◯No If yes, how much/ often: ◯Occasional ◯1/2 pack/day ◯ 1 pack/day ◯1+ pack
Hobbies/Interests: _____

Extra Tests Not Covered by Insurance

The office is now offering retinal photography to better monitor your eye health. Digital photos allow us to document both healthy retinas and retinas that may be affected by diseases such as glaucoma, macular degeneration, diabetes, and hypertension. **The procedure is not covered by insurance unless there is a medical diagnosis.** The fee for this service is $18.00 which is separate from the regular exam charges.

◯Yes, I would like to have the retinal photography. ◯No, I do not wish to have the retinal photography.
◯I have questions for Dr. Albert before deciding to have the retinal photography.

The FDT is a visual field analyzer that can assist us in detecting sight threatening diseases such as glaucoma as well as tumors of the eye and brain. Dr. Albert recommends that this test be performed on everyone. We charge a fee of $10.00 which is **not covered by insurance**.

◯I agree to have the FDT. ◯I do not wish to have the FDT.
◯I have questions for Dr. Albert before deciding to have the FDT

_____ ____/____/____
Signature Date