O'Reilly Cross Family Eyecare, Inc

RCA Optical, 56 Worcester Rd, Webster, MA 01570
P: 508-943-9057 F: 508-943-9067
Inside Target Optical, 529 Lincoln St, Worcester, MA 01605
P: 508-863-3999 F-508-943-9067

Dr Blair O'Reilly, OD
Dr Tyla Girouard, OD

Confidential Internal Patient Registration Form

Patient's Legal Name:				Pref Name:	
Mailing Address:				Date of Birth:	
City:	State:	Zip:	Sex Assigned at Birth: ☐ Male ☐ Female		
Email:			Gender Identity:		
Home Phone:	Cell Phone:		Alt. Phone:		
Occupation/School Grade:			Employer/School:		

Insurance Type	Insurance Co.	Member ID	Primary Card Holder (PCH)	PCH Date of Birth	Relationship to Patient
Medical					
Vision					

Emergency Contact (ICE) 1:	ICE Phone:	ICE Relationship:
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VISION HISTORY

Wear Glasses: ☐ Yes ☐ No	What for: ☐ Distance ☐ Near ☐ Both	
Years wearing glasses:	Age of current prescription in glasses:	
Wear Contact Lenses: ☐ Yes ☐ No	Years wearing Contact Lenses:	How often:
Brand/ Type of contact lens currently wearing:		
Are you happy with the comfort of your lenses? If not, please explain:		

Patient Name: Date of Birth:

MEDICAL HISTORY

Have you or any of your relatives (parents, siblings, grandparents, or children) ever had any of the following? Check all that apply and **explain** relationship to patient.

Macular Degeneration	☐ :	Cataract	☐ :	Glaucoma	☐ :
Retinal Detachment	☐ :	Eye Disease	☐ :	Eye Injury	☐ :
Amblyopia (lazy eye)	☐ :	Eye Turn	☐ :	Eye Pain	☐ :
Sensitivity to Light	☐ :	Blind Eye	☐ :	Eye Infection	☐ :
High Blood Pressure	☐ :	Eye Patching	☐ :	Eye Surgery	☐ :
Thyroid Trouble	☐ :	Heart Disease	☐ :	Headaches	☐ :
Double Vision	☐ :	Diabetes	☐ :	Cancer	☐ :
Other	☐ :	Allergies:			

Use Tobacco:	☐ Yes	☐ No	Drink Alcohol:	☐ Yes ☐ No

Primary Care Doctor:	Phone:
Specialist Care Doctor:	Phone:

Are you under the care of a physician for any medical condition currently? If so, please explain:

Please list any medications you are currently taking (if you have a list, we can make a copy):

Please briefly state the MAIN reason for wanting an eye exam today:

FINANCIAL RESPONSIBILITY & PRIVACY POLICY

Thank you for choosing O'Reilly Cross Family Eyecare, Inc. for your eye care needs. As a Courtesy, our office will file your insurance claim based upon the information given prior to your visit. If your claim is denied, it becomes your responsibility to pay the balance in full. ALL copays/fees are due at time of service. We will assist you in any way possible.

By signing below, I agree that I am ultimately responsible for payment of services provided to me. My signature below authorizes O'Reilly Cross Family Eyecare, Inc. to release the information necessary to facilitate the payment of medical claims. My signature below also acknowledges my decision regarding my retinal evaluation and that I was offered/received a copy of O'Reilly Cross Family Eyecare, Inc.'s "Notice of Privacy Act, HIPAA Policy". Finally, I confirm the receipt of my glasses and/or contact lens prescriptions which is attained at the end of a routine eye examination or contact lens evaluation.

Signature:**	Date:

****This must be the name/signature of a Parent/Guardian if Patient is under 18 years of age - Thank you!**

Print Name:**	Relationship: