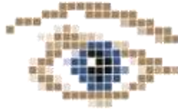


TIMOTHY D. RIOUX, O.D.
OPTOMETRIST

Patient Registration Form

Name____ Today's Date _________________

Date of Birth ___/___/_____ Gender ☐ Male ☐ Female Marital status_________________

Mailing address____

Phone numbers: Home (______)______-________ Work (______)______-________
Mobile (______)______-________ E-mail _______________________

The best way to remind you of your next appointment: ☐Home ☐Mobile ☐Work ☐E-mail ☐Text
Preferred language: ☐English ☐French ☐Other:________________

Emergency contact ________________________________ Relationship_____________________
Address____ Phone number (______)______-________

Race:
☐White ☐American Indian ☐Asian
☐African American ☐Other

Ethnicity:
☐Hispanic ☐Latino
☐Neither ☐Other

Do you have medical insurance? ☐ Yes ☐ No
Responsible party: ☐Self ☐Spouse ☐Dependent ☐Child ☐Other:__________________________
Name____ Date of Birth____/____/______
Address____Phone number (____)____-______
Occupation_________________________Employer_____________________________________

Name of primary insurance carrier:______________________________ Policy number____________
Policy holder & Date of birth______________________________Group Number_______________

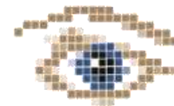
Name of secondary insurance carrier:____________________________ Policy number___________
Policy holder & Date of birth______________________________Group Number_______________

Name of tertiary insurance carrier:______________________________ Policy number___________
Policy holder & Date of birth______________________________Group Number_______________

Insurance Authorization: I hereby assign all medical and/or routine benefits to which I am entitled, including Medicare or any private health plan to: Dr. Timothy D. Rioux, O.D. This assignment is considered as valid as an original. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber’s responsibility as defined by my insurance company, particularly co-payments and deductibles.

____ ________________________
Signature of subscriber *Date*

Name________________ Date of Birth ___/___/_____ Today's Date ___/___/_____



TIMOTHY D. RIOUX, O.D.

OPTOMETRIST

Patient History Form

Reason for today's visit

☐ blurry spot in vision
☐ blurry vision
☐ bump on eyelid(s)
☐ burning sensation
☐ crossed eyes
☐ diabetic eye exam
☐ discharge
☐ distorted vision
☐ dizziness
☐ double vision
☐ droopy lid(s)
☐ dry eye(s)
☐ eye lashes turn in
☐ follow up exam
☐ flashes
☐ floaters
☐ foreign body sensation
☐ glare
☐ glasses re-check
☐ glaucoma evaluation
☐ headaches
☐ itchy eye lid
☐ itchy eyes
☐ injury
☐ loss of vision
☐ pain in eye(s)
☐ red eye(s)
☐ swelling
☐ watery eye(s)
☐ routine eye exam
☐ other:__________

Glasses history: *Skip if you do not wear glasses*

What glasses do you own? ☐ Single Vision ☐ Bifocals ☐ Safety Glasses ☐ Progressive ☐ Trifocals ☐ Sunglasses ☐ Sports Glasses ☐

How many hours a day do you use a computer?_____

How many inches away, approximately, do you sit from your computer monitor?_____

Please check off any current conditions you suffer from:

☐ I am having problems with my current glasses
☐ There are times when I would rather not be wearing glasses
☐ My spare glasses are no longer useable
☐ I am in need of updating my sunglasses
☐ I have problems with night vision
☐ I am allergic to nickel
☐ I have problems with glare
☐ I do not have a spare set of glasses

Contacts history: *Skip if you do not wear contacts*

What brand of contact lenses do you wear? _________________________

How old are your current contact lenses? ____________________

How often do you replace or dispose your contact lenses? ____________________

How often do you change your contact lens case? ____________________

What brand of solution do you soak your lenses in? ____________________

What is your typical wearing schedule? Hours/day______ Days/week______

Please check off any current conditions you suffer from:

☐ I am having problems with my current contact lenses

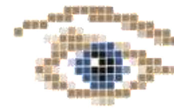
☐ They tear easily ☐Uncomfortable ☐Contacts are dry ☐Vision has changed

☐ There are times when I would rather not be wearing contact lenses
☐ I am interested in changing or enhancing my eye color
☐ I do not have a spare set of contact lenses
☐ I am in need of more contact lenses
☐ I am interested in refractive laser surgery

What eye problems have you had in the past? *Please check all that apply.*

☐None
☐Glaucoma
☐Diabetic Retinopathy
☐Macular Degeneration
☐Cataracts If yes, have you had cataract surgery?___________ Dates performed_____________________
☐Other eye surgeries __________________ Surgeon_________________ Date performed_________________
__________________ Surgeon_________________ Date performed_________________

Name________________ Date of Birth ___/___/_____ Today's Date ___/___/_____



TIMOTHY D. RIOUX, O.D.

OPTOMETRIST

Family eye history: *Have any of your family members had any of the following eye problems? Please check appropriately, and indicate your relation.*

☐Glaucoma__________________________________ ☐Cataracts__________________________________

☐Retinal Detachment__________________________ ☐Diabetic Retinopathy________________________

☐Macular Degeneration________________________ ☐Strabismus*(eye turn)*________________________

☐Amblyopia*(lazy eye)*__________________________ ☐Other______________________________________

Family medical history: *Have any of your family members had any of the following health problems? Please check appropriately, and indicate your relation.*

☐Diabetes___________________________________ ☐Cancer____________________________________

☐Hypertension _______________________________ ☐Heart Disease______________________________

☐High Cholesterol_____________________________ ☐Stroke____________________________________

☐Kidney Disease______________________________ ☐Other_____________________________________

Medication allergies – *Please list medication and reaction that occurs when taken.*

____ ____

____ ____

____ ____

Current eye medications - *Prescriptions and over the counter.*

Medication	*Dosage*	*Frequency*	*Which eye*	*Last time of dose*

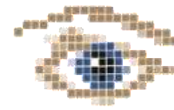
Other prescription medications – *Over the counter and vitamins. If you already have a list prepared, please present at the time of examination.*

Medication	*Dosage*	*Frequency*	*Last time of dose*

Past surgeries – *Date performed and performing surgeon*

Surgery	**Date performed**	**Performing surgeon**

Name________________ Date of Birth ___/___/_____ Today's Date ___/___/_____



TIMOTHY D. RIOUX, O.D.
OPTOMETRIST

Medical History Form – *Please check if you have any of the following.*

Ears, Nose, and Throat
☐Hard of hearing
☐Ringing in the ears
☐Vertigo/Dizziness
☐Sinus problems/Infections
☐Other: _________________

Psychiatric
☐Anxiety
☐Depression
☐Mood Swings
☐Difficulty Sleeping
☐Bipolar Disorder
☐Other: _________________

Kidneys (Genitourinary)
☐Kidney infections
☐Kidney Stones
☐Urinary infections
☐Pain upon urination
☐History of STD
☐Other: _________________

Blood and Lymph Nodes (Hematologic)
☐Easy bruising
☐Prolonged bleeding
☐Clotting problems
☐Anemia
☐Other: _________________

General
☐Unexplained weight loss
☐Lack of energy
☐Allergies
☐Other: _________________

Brain and Neurological
☐Seizures
☐Stroke
☐Weakness
☐Paralysis
☐Numbness/tingling
☐Tremors
☐Migraines
☐Brain damage/trauma
☐Other: _________________

Heart and Blood Vessels (Cardiovascular)
☐Chest pain
☐Fainting spells
☐Irregular heart beat
☐High blood pressure
☐High cholesterol
☐Pacemaker
☐Heart Attack
☐Circulation problem
☐Heart murmur
☐Other: _________________

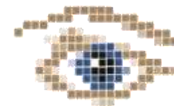
Digestive *(Gastrointestinal)*
☐Heartburn
☐Nausea/vomiting
☐Acid reflux
☐Ulcers
☐Diverticulitis
☐Crohn's disease/colitis
☐Hepatitis
☐Other: _________________

Lungs (Respiratory)
☐Cough
☐Shortness of breath
☐Wheezing
☐Asthma
☐COPD
☐Bronchitis
☐Tuberculosis
☐Other:_________________

Muscles and Bones *(Musculoskeletal)*
☐Joint stiffness
☐Joint pain
☐Arthritis
☐Joint swelling
☐Osteoporosis
☐Muscle pain
☐Other: _________________

Endocrine
☐Type I Diabetes
☐Type II Diabetes
☐Insulin dependent
☐Hypothyroidism
☐Grave's disease
☐Other: _________________

Skin (Integumentary)
☐Rashes
☐Sores
☐Lesions
☐Hives
☐Skin Cancer
☐Psoriasis
☐Other: _________________



TIMOTHY D. RIOUX, O.D.
OPTOMETRIST

Release of Medical Records

Patient name: ________________________ Date of Birth____/____/______

☐Release to
OR
☐Obtain from

☐ I authorize ____________________ to share my information from my records with the following people of health care facilities:
OR
☐ I choose not to share my information with anyone.

Name _Timothy D Rioux OD
Address 29 Meadow Lane
Fort Kent, ME 04743
Relationship New Eye Doctor
Phone number (207) 834-3333
Fax number (207) 834-6095

Share ALL Information	Appointment	Testing	Treatment	Health History
☐	☐	☐	☐	☐

Name __________________________
Address_________________________________
____
Relationship_______________________
Phone number (____)____-______
Fax number (____)____-______

Share ALL Information	Appointment	Testing	Treatment	Health History
☐	☐	☐	☐	☐

____________I **DO** authorize release of information regarding mental health treatment.
(initials required)

____________I **DO** authorize release of information regarding drug or alcohol abuse treatment.
(initials required)

____________I **DO** authorize release of information regarding HIV/AIDS and STD diagnosis/treatment.
(initials required)

____________I **DO** authorize release of information regarding pregnancy and abortion.
(initials required)

____________I **DO NOT** wish to review any records before they are released.
(initials required)

I understand that once this information is released, it is subject to redisclosure by the receiving party.

Signature____ Date____/____/______

Patient must sign, except when there is a Power Of Attorney on file, legal guardianship or the patient is a minor. The consent to release is effective until_____________, (one year from today's date) and is authorized for future disclosures regarding these records to the same individuals or entities during this time period. This authorization may be revoked at anytime.