WELCOME TO OUR OFFICE

Gene Harrison, O.D. Gary C. Few, O.D.

Todays's Date _____

Last _____ First _____ MI _____

Date of Birth _____ Age _____ Sex M F

Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Patient's SSN _____

Employer (or School) _____ Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Email Address _____

What is the major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Subscriber Contract # _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Subscriber Contract # _____

How will you settle your account today?

□ Cash □ Check □ Credit Card

FAMILY MEDICAL/EYE HISTORY (CHECK ALL THAT APPLY)

Is there a family history of any of the following?

	Relationship
Blindness	□ _____
Cataracts	□ _____
Corneal Problems	□ _____
Glaucoma	□ _____
Lazy Eye	□ _____
Macular Degeneration	□ _____
Retinal Problems	□ _____
Diabetes	□ _____
Heart Disease	□ _____

The information in this confidential case history form is critical to the evaluation of your vision health.

PATIENT MEDICAL HISTORY

Name of Family Physician _____

Town _____

Date of Last Physical Check -up _____

CURRENT MEDICATIONS (Rx or Over the Counter)

List name of medication including eye drops, vitamins, & birth control pills) _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications: □ Yes □ No

Have you ever been diagnosed or treated for the following?

□ Allergies	□ Diabetes	□ Thyroid
□ Asthma	□ Heart Disease	□ Other
□ Arthritis	□ High Blood Pressure	_____
□ Cancer	□ Kidney	_____
□ Cholesterol	□ Nerves	_____

PATIENT EYE HISTORY

Date of last Eye Exam_____
By Whom?_____
Do currently wear contact lenses? ◻ Yes ◻ No
What Kind? _____
Solutions Used _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes?_____
Have you ever tried contact lenses? ◻Yes ◻ No

Do you.....(Chech box if your answer is yes)

◻..Work at a computer?
◻...Think you might benefit from thinner, lighter lenses?
◻...Have interest in a *Test Drive* of the latest contact lens designs?
◻...Spend time outdoors? (How much?) _____hrs/week
◻...Have prescription sunglasses?
◻...Prefer not to wear your glasses at times?
◻...Want information on Laser Vision Correction surgery?
◻...Have interest in a non-surgical approach to vision correction?
◻...Have more than 1 pair of current Rx glasses?
◻...Have children?
◻...Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you?
◻ Yes ◻ No
If you wear contact lenses, are you satisfied with the vision and comfort? ◻ Yes ◻ No

Have you ever been diagnosed or treated for the following?

◻ Cataracts ◻ Iritis/Uveitis
◻ Corneal Abrasion ◻ Lazy Eye
◻ Eye Infection ◻ Macular Degeneration
◻ Eye Injury ◻ Retinal Detachment
◻ Glaucoma ◻ Other eye disorders

Do you experience or have you ever experienced?

◻ Blurry Vision ◻ Flash of light ◻ Sunlight Sensitivity
◻ Burning ◻ Floater/spots ◻ Crossed eye/eye turn
◻ Tearing ◻ Grittiness ◻ Trouble seeing at night
◻ Headaches ◻ Itchiness ◻ Uncomfortable glasses
◻ Double Vision ◻ Occasional dryness

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Dr. Harrison / Dr. Few O.D.,

Notice of Privacy Practices. Date _____

Patient name _____ Signature_____

ASSIGMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with_____ _____ and assign directly to Dr. Harrison and Dr. Few all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Certain routine services and/or materials that we feel are necessary for good health may not be covered by your insurance. You will be expected to pay for those services and/or materials in full. Should my account become delinquent and require services of a collection agency or an attorney, I will pay reasonable collection fees, attorney fees, and all court costs for collection. I have read the above policies and agree as indicated by my signature.

_____

PATIENT OR RESPONSIBLE PARTY DATE