Welcome to Harrison Eye Care

Legal Name: Last ______________________________ First ______________________________ M.I._____

Date of Birth: ______________________________ **Gender:** Male / Female

Date of Last Eye Exam: ___________________________ **Dilated?** *Yes / No*

Medical Information

How is your general health? ____

Do you take medications for any of these symptoms? (Please circle yes or no)

Gastrointestinal	*Yes/No*	Nervous	*Yes/No*	Endocrine (glands)	*Yes/No*
Ears/Nose/Throat	*Yes/No*	Urinary	*Yes/No*	Blood/Lymph	*Yes/No*
Cardiovascular	*Yes/No*	Muscles/Bones	*Yes/No*	Allergic/Immunologic	*Yes/No*
Respiratory	*Yes/No*	Integumentary (skin)	*Yes/No*	Headaches	*Yes/No*
High blood pressure	*Yes/No*	Eyes	*Yes/No*	Mental	*Yes/No*

Please explain ____

Diabetes *Yes/No* Type ____________________ Date of Diagnosis ________________________________

Allergies to medication *Yes/No* Which? _________________ Reactions? ____________________________________

Other health problems ____

Current medication(s) ____

Have you had any operations? *Yes/No* Kind? ____

Current family doctor and/or primary care physician:

Name ____ Date of last visit ___________________

Address____ City, State, Zip ___________________________________

Other health care specialist:

Name ____ Date of last visit ___________________

Address____ City, State, Zip ___________________________________

Family History

High blood pressure	*Yes/No*	Glaucoma	*Yes/No*	Retinal detachment	*Yes/No*
Diabetes	*Yes/No*	Macular degeneration	*Yes/No*	Cataracts	*Yes/No*

Personal Eye Information

Do you have any eye conditions or problems? *Yes/No* What kind? ____

Have you had any eye operations? *Yes/No* Type __________________________________ When ______________

Have you had an eye injury? *Yes/No* Kind __________________________________ When ______________

Do you have glaucoma?	*Yes/No*	Cataracts?	*Yes/No*	Dry eyes?	*Yes/No*
Macular degeneration?	*Yes/No*	Retinal detachment?	*Yes/No*	Blurred vision?	*Yes/No*

Do you wear glasses? *Yes/No* Contact lenses? *Yes/No* Type ___________________________________

Additional information ____

Work/Tasks

Typical work tasks: ___**C**omputer Other ____

Signature: ____ **Date:** ____________________

Harrison Eye Care

Name _________________________________ DOB: ___________
Address ____
____
Home Ph:______________________ Day Ph:__________________
Cell Ph: _______________________

Name Preference/Nickname: ____________________ Title (Please circle): Mr. / Mrs. / Ms. / Miss / Dr. / Other: _____

Age: _____ Birth Date: __________ Marital Status (please circle): Single/Married/Divorced/Widowed/Legally Separated

SSN (or last 4 digits **Required)**______________________________________ Gender(Please circle): Male or Female

Email: ____

Communication Preference (please circle one): Postal / Home Phone / Cell Phone / Text / Email

For improved communication may we please send an email to notify you of the following: ___ Yes ___ No

- ✓Glasses/contact lenses ready for pickup
- ✓Appointment reminder/ annual recall notice (no more postcards!)
- ✓Newsletter (4 times per year)

Referred by (please circle): Patient/Professional/Other/None Name: ____________________________________
List other family members seen at this office: ____
Employer (or school): ______________________________Occupation (or grade in school): ________________

Required Information (please check ONE in EACH CATEGORY):

Race:	Ethnicity:	Preferred Language:
__ White	__ **Not** Hispanic or Latino	__ English
__ Black or African American	__ Hispanic or Latino	__ Spanish
__ Hispanic	__ Native Hawaiian/Other Pacific Islander	__ Japanese
__ Asian		__ French
__ American Indian or Alaskan Native		
__ Native Hawaiian/Other Pacific Islander		

I acknowledge receipt of Harrison Eye Care's Notice of Privacy Practices (please initial) ______

(The Harrison Eye Care Privacy Policy is available for review at the front desk. Copies are available upon request.)

Person financially responsible for this account: ________________________ SSN (or last 4 digits): ___________

How is this person related to patient (circle): Self/Spouse/Father/Mother/Guardian/Other __________

If minor, parents full names: Father _________________________ Mother ________________________

Do you have vision insurance through Vision Service Plan (VSP): Yes/No Medicare: Yes/No
If yes: Insured's Legal Name: ____________________________________ SSN (or last 4 digits)/ID#: _________

PAYMENT POLICY:

Payment is required at the time of service. You are responsible for all fees and will be reimbursed directly by your insurance carrier if you are eligible for coverage. Does not apply to Vision Service Plan (VSP) or Medicare.
Please circle your method of payment: Check Cash Visa Mastercard Discover

Patient/Guardian Signature: ____ Date: ______________