Gene Harrison, O.D.

WELCOME TO OUR OFFICE

Today'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	_____