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_____

ASSIGNMENT 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