Patient Registration & Medical History Form

Please be sure to bring your medical insurance card, any eyewear, contact lenses and contact solution.

First Name: ____________________ Last Name: ______________________________ Middle Initial: ____ Preferred Name: ____________________

Birth Date: ____________________ Social Security #: __________________ Sex: ☐ **M** ☐ **F**

Home Address: ____ Zip: __________ City: __________________________ State: ______

Which phone number would you prefer we use to contact you? ☐ **Home** ☐ **Work** ☐ **Cell** Home Phone: ______________ Work Phone: ________________

Cell Phone: _______________ Would you like us to email you for orders/appointments, etc? ☐ **Y** ☐ **N** E-mail address: ______________________________

Notify in case of emergency: ______________________________ Phone: _______________________ Relationship: ________________________________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other** ***We must have a copy of all insurance cards on the day of service**

Primary Medical Insurance & #: ____ Secondary Medical Insurance: ____________________________________

Vision Insurance & #: ____ Insured Social Security Number: ___________________________________

Insured's Name: ____ Insured's Birth Date: _____________________

Insured's Employer: _________________________________ Family Doctor: _______________________________

Last Eye Doctor: _____________________________________ When was your last eye exam? __________________ Last Physical? __________________

HOW DID YOU HEAR ABOUT US? ____ Referred by: ____________________________________

CHIEF COMPLAINT

What is the main reason for your appointment today? Please check/explain any signs and/or symptoms you are experiencing.

☐ **Flashes of light**	☐ **Floaters**	☐ **Eye pain/soreness**	☐ **Glare**	☐ **Dry eyes**	☐ **Discharge**
☐ **Blurred vision**	☐ **Crossed eyes**	☐ **Watery eyes**	☐ **Light sensitivity**	☐ **Red eyes**	
☐ **Double vision**	☐ **Eyestrain**	☐ **Sandy/gritty feeling**	☐ **Tired eyes**	☐ **Burning/Itching**	

Other (explain): ____

HISTORY OF PRESENT COMPLAINT

Location *Which eye has the problem?* ☐ **Right** ☐ **Left** ☐ **Both**
Quality *How is it affecting you?* ______________________________
Severity *How severe is the problem?* ☐ Mild ☐ Moderate ☐ Severe
Duration *How long have you had the problem?* ____________________

Timing ☐ **Gradual** ☐ **Sudden** ☐ **Intermittent** ☐ **Continuous**
Context *Associated w/:* ☐ **Infection** ☐ **Medical condition** ☐ **Injury** ☐ **Surgery**
Modifiers *Previous treatment?* ☐ **Drops** ☐ **Medication** ☐ **Other:** _________
Symptoms *Are there associated symptoms?* ☐ **Headache** ☐ **Other:** _________

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):

☐ **Diabetes** ☐ **High blood pressure** ☐ **Cancer**

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):

☐ **Glaucoma** ☐ **Amblyopia** ☐ **Cataracts** ☐ **Macular degeneration** ☐ **Strabismus (eye turn)** ☐ **Blindness** ☐ **Retinal detachment**

PAST HISTORY

List any major illnesses, injuries or surgeries you have had in the past: ____

____

SOCIAL HISTORY

Do you smoke? ☐ Y ☐ N
If yes, what do you smoke? ☐ **Cigarettes** ☐ **Cigars** ☐ **Pipes**
How much do you smoke? ____________________

Do you consume alcohol? ☐ Y ☐ N
If yes, how much do you drink? ____________________

What is your occupation? ____________________ Hobbies: ____________________ Sports: ____________________

CURRENT VISION

Glasses: Do you currently wear glasses? ☐ Y ☐ N **if yes, answer the questions below; if no, continue to contact lenses section.**
What type of lenses are in your glasses? ☐ **Single vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **No-line (Progressive)**

Contact Lenses: Do you currently wear contact lenses? ☐ Y ☐ N if yes, answer the questions below; if no, are you interested in CL's? ________
What type of contact lenses do you wear? ☐ Soft ☐ Rigid
What is the brand of your contact lenses? ____________________
What are the powers of your contact lenses (if you know)? ____________________
How old are your current contact lenses? ______ Weeks ______ Months ______ Years
How often do you replace your contact lenses? ☐ Daily ☐ Weekly ☐ 2 weeks ☐ Monthly ☐ 3 months ☐ 6 months ☐ Annually
What solutions do you use to care for contact lenses? ☐ Renu ☐ Optifree ☐ Clear Care ☐ Boston Advance ☐ Boston Simplicity ☐ Optimum ☐ Other: ______

REVIEW OF SYSTEMS *Please check all that apply to you*

Ocular/Eye
- Surgery ☐ Y ☐ N
- Glaucoma ☐ Y ☐ N
- Amblyopia (lazy eye) ☐ Y ☐ N
- Cataract ☐ Y ☐ N
- Retinal problems ☐ Y ☐ N
- Macular degeneration ☐ Y ☐ N
- Strabismus (eye turn) ☐ Y ☐ N
- LASIK ☐ Y ☐ N
- Other __________

Constitutional
- Fatigue ☐ Y ☐ N
- Fever ☐ Y ☐ N
- Weight Loss ☐ Y ☐ N
- Other __________

Ears, Nose, Mouth, Throat
- Dry mouth ☐ Y ☐ N
- Hearing loss ☐ Y ☐ N
- Sinusitis ☐ Y ☐ N
- Other __________

Cardiovascular
- Vascular disease ☐ Y ☐ N
- High cholesterol ☐ Y ☐ N
- Heart disease ☐ Y ☐ N
- High blood pressure ☐ Y ☐ N
- Stroke ☐ Y ☐ N
- Other __________

Respiratory
- Tuberculosis ☐ Y ☐ N
- COPD ☐ Y ☐ N
- Asthma ☐ Y ☐ N
- Other __________

Gastrointestinal
- Colitis ☐ Y ☐ N
- Crohn's disease ☐ Y ☐ N
- Ulcer ☐ Y ☐ N
- Other __________

Genitourinary
- Prostate disease/cancer ☐ Y ☐ N
- STD ☐ Y ☐ N
- Kidney disease ☐ Y ☐ N
- Other __________

Musculoskeletal
- Fibromyalgia ☐ Y ☐ N
- Muscular dystrophy ☐ Y ☐ N
- Osteoarthritis ☐ Y ☐ N
- Other __________

Skin
- Rosacea ☐ Y ☐ N
- Psoriasis ☐ Y ☐ N
- Eczema ☐ Y ☐ N
- Other __________

Neurological
- Dementia ☐ Y ☐ N
- Multiple sclerosis ☐ Y ☐ N
- Shingles ☐ Y ☐ N
- Migraine headache ☐ Y ☐ N
- Epilepsy ☐ Y ☐ N
- Other __________

Psychiatric
- Depression ☐ Y ☐ N
- Anxiety ☐ Y ☐ N
- Other __________

Endocrine
- Type 1 diabetes ☐ Y ☐ N
- Type 2 diabetes ☐ Y ☐ N
- Hormonal dysfunction ☐ Y ☐ N
- Thyroid dysfunction ☐ Y ☐ N
- Other __________

Blood/Lymph
- Anemia ☐ Y ☐ N
- Bleeding Disorder ☐ Y ☐ N
- Other __________

Allergy/Immunologic
- Environmental allergies ☐ Y ☐ N
- Rheumatoid arthritis ☐ Y ☐ N
- Drug allergies ☐ Y ☐ N
- Lupus ☐ Y ☐ N
- HIV/AIDS ☐ Y ☐ N
- Other __________

Do you sometimes experience dry eyes? ☐ Y ☐ N

Are your eyes sensitive to sunlight? ☐ Y ☐ N

Do you work at a computer? ☐ Y ☐ N

Problems with reflections and/or glare? ☐ Y ☐ N

Prefer not to wear your glasses at times? ☐ Y ☐ N

Interested in newer contact lens technology? ☐ Y ☐ N

Interested in thinner/lighter lenses? ☐ Y ☐ N

Like information on LASIK vision surgery? ☐ Y ☐ N

List any medicine allergies:
____
____

List any other allergies:
____
____

Are you currently pregnant or nursing? ☐ Y ☐ N

Current height and weight:
____

MEDICATIONS

List all medications you take: (prescription and over-the-counter) Attach list if necessary.

	(Name)	(Dosage)	(How Often)
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

Pharmacy: ____ Pharmacy Phone: ___________________________

OFFICE AGREEMENT

NOTICE OF PRIVACY PRACTICES: The Harmony EyeCare HIPAA Notice of Privacy Policy has been made available to me and is available on the company's website at www.harmonyeyecare.com.

OFFICE POLICY ON PAYMENT: Unless other payment arrangements are made in advance, Harmony EyeCare requires payment in full for examination fees and all materials at the time of service or ordering. If an insurance claim will be filed by Harmony EyeCare on your behalf, you will be required to pay any deductibles and co-pays at the time of service.

INSURANCE: Harmony EyeCare will file your claims with your insurance company as a courtesy, but you are ultimately responsible for all fees for both services and materials delivered to you by this office. Verification of eligibility by your insurance company is not a guarantee of payment, coverage, or benefits. Not all services are covered benefits in all vision and insurance plans, and routine eye care and other selected procedures may be specifically excluded, making you responsible for the charges. It is your responsibility to know and understand what services are covered under your vision or medical policy. If you have any questions whether a service will be covered you are urged to contact your insurance company before services are provided. If we have not received payment from your insurance carrier within 45 days of initial service the balance will be transferred to you for payment.

VISION PLAN COVERAGE: The vision plan to be used must be chosen before the exam occurs and cannot be changed at a later date. If you are covered under 2 vision plans, your primary plan must be used first. If the primary reason for your visit is medical in nature, your medical plan will be billed instead.

MEDICAL PLAN COVERAGE: In most cases, medical insurance will cover the cost of services only if there is a medical necessity for the exam or test, such as eye infections, cataracts, diabetes, etc. If your coverage requires a referral from your primary healthcare provider to see us, it is your responsibility to obtain that referral prior to your examination.

CONTACT LENS FEES: Contact lens examinations will be subject to a contact lens evaluation fee in addition to the exam fee. This includes one follow-up visit. All other contact lens visits may be subject to additional fees.

PAYMENT: We accept cash, checks, money orders, Visa, MasterCard, Discover, and Care Credit. An overdraft fee of $35.00 will be assessed for all returned checks. I understand any unpaid balances on my account after 30 days will accrue interest at an annual rate of 18% and that I will be responsible for any costs associated with the collection of past-due balances.

AUTHORIZATION TO BILL: I have read and understand the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Harmony EyeCare for services and/or materials rendered and I authorize the use of this signature on all insurance submissions. I authorize Harmony EyeCare to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf and/or to secure the payment of benefits by any third party payers, including, but not limited to any insurance carriers, Social Security Administration, and Worker's Compensation.

AUTHORIZATION TO TREAT: I authorize Harmony EyeCare to furnish optometric care and services, including but not limited to diagnostic tests, examinations, and other medical procedures which are deemed necessary in the course of my care.

SIGNATURE: ____ **DATE:** ________________________

Patient or Parent/Guardian