Welcome!

Harmony EyeCare

Patient Information

Date: ______________ Date of Birth: ______________

Name: ____

First Name M Last Name

Sex: ☐ Male ☐ Female

Address: ____

City: ____

State: ____________ Zip Code: ______________

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: ____

Emergency Contact/Relationship: ______________________

Social Security #: ______________________

Email Address______________________

Employer: ______________________

Occupation: ______________________

Work Phone: ______________________

Emergency Phone #: ______________________

♦ NEW PATIENTS: WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?______________________

If not referred, how did you hear about us? ☐ Friend/Relative ☐ Insurance ☐ Yellow Pages ☐ Newspaper ☐ Sign ☐ Internet

Financial & Insurance Information

Who is responsible for payment? ______________________

Address: ______________________

City: ______________________

State: ______________ Zip Code: ______________

SSN: ______________________

Home Phone: ______________________

Relationship to Patient: ______________________

Birth Date: ______________________

Insurance: ______________________

Member #: ______________________

Group #: ______________________

Work Phone: ______________________

Eye Health History

Name of last eye doctor: ______________________

Approximate date of last eye exam: ______________________

Are you interested in LASIK? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No

Do you currently wear contacts? ☐ Yes ☐ No

♦If no, are you interested in contacts? ☐ Yes ☐ No

Check the box if you have recently experienced or been diagnosed with any of the following:

Bloodshot eyes	☐	Floaters or spots in vision	☐
Blurred vision-distance	☐	Glaucoma	☐
Blurred vision-near	☐	Headaches	☐
Burning in eyes	☐	Itching eyes	☐
Cataracts	☐	Light Sensitivity	☐
Crossed eyes	☐	Migraine headaches	☐
Discharge from eyes	☐	Poor color vision	☐
Dizzy spells	☐	Poor night vision	☐
Double vision	☐	Red eyes	☐
Dry eyes	☐	Seeing flashes of light	☐
Eye infection	☐	Seeing halos	☐
Eye injury	☐	Temporary loss of vision	☐
Eye strain	☐	Twitching eyelid	☐
Fainting spells	☐	Watering eyes	☐

-Please turn over and complete other side-

Health History

Name of general practitioner: ______________________________

Check the appropriate box if you or any **blood** relatives have had any of the following medical conditions:

	Yourself	Blood Relatives		Yourself	Blood Relatives
Hay fever	☐	☐	Gastrointestinal Condition	☐	☐
Artificial heart valve	☐	☐	AIDS or HIV	☐	☐
Heart condition	☐	☐	Hepatitis	☐	☐
High blood pressure	☐	☐	Kidney disease	☐	☐
High cholesterol	☐	☐	Rheumatic fever	☐	☐
Pacemaker	☐	☐	Currently pregnant	☐	☐
Stroke	☐	☐	Shingles	☐	☐
Lupus	☐	☐	Skin conditions	☐	☐
Diabetes	☐	☐	Artificial joints	☐	☐
Thyroid condition	☐	☐	Rheumatoid arthritis	☐	☐
Blindness	☐	☐	Epilepsy	☐	☐
Cataracts	☐	☐	Depression	☐	☐
Eye injury or surgery	☐	☐	Asthma	☐	☐
Glaucoma	☐	☐	Emphysema	☐	☐
Lazy eye or amblyopia	☐	☐	Tuberculosis	☐	☐
Macular degeneration	☐	☐	Chemical dependency	☐	☐
Poor color vision	☐	☐	Migraine headaches	☐	☐
Retinal disease	☐	☐	Cancer	☐	☐

Other pertinent health information: ______________________________

Do you smoke? ☐ Yes ☐ No Packs/day? Do you drink alcohol? ☐ Yes ☐ No #/day?

Medications

List any medications and dosages you currently take, including eye drops: ☐ None

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____

____

List any allergies to medications or other substances that you have: ☐ None

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____

Authorization, Financial Policy & HIPAA Statement

I authorize Harmony EyeCare to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers, health practitioners, and/or employers until otherwise requested in writing. I assign all insurance benefits, if any, to Harmony EyeCare otherwise payable to me for services rendered. 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.

Harmony EyeCare requires payment in full for examination fees and all materials at the time of service or ordering. We accept cash, checks, money orders, Visa, Mastercard, and Discover. An overdraft fee of $25.00 will be assessed for returned checks. Client(s) will be responsible for any balances owed. If balances are not paid, the client will be responsible for all collection agency fees and attorney fees totaling 200% of the account balance.

Contact lens examinations will be subject to a contact lens fitting fee with one free follow-up. All other contact lens checks or follow-ups may include additional fees.

"I have read the Harmony EyeCare HIPAA Notice of Privacy Policy posted either on the web site or in the office waiting area."

"I have read the contents of this page and understand by signing my name, I agree to all of the terms and conditions."

Signature: ______________________________ Date: ______________