

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.....(Check 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
- Corneal Abrasion
- Eye Infection
- Eye Injury
- Glaucoma
- Iritis/Uveitis
- Lazy Eye
- Macular Degeneration
- Retinal Detachment
- Other eye disorders

Do you experience or have you ever experienced?

- Blurry Vision
- Burning
- Tearing
- Headaches
- Double Vision
- Flash of light
- Floater/spots
- Grittiness
- Itchiness
- Occasional dryness
- Sunlight Sensitivity
- Crossed eye/eye turn
- Trouble seeing at night
- Uncomfortable glasses

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