VISION SOURCE
BRET W. HARRISON, O.D.

PATIENT HISTORY QUESTIONNAIRE

Welcome to our office. We are glad you have chosen us to provide your eye care needs.
Please complete **Front and Back** and return it to the receptionist (**must be updated each visit**).

PATIENT RECORD

Mr.___ Mrs.___ Miss___ Ms.___ Married___ Single___ Other___ **Date:_____**

Name: Last_____ First_____ MI_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____
Date of Birth:_____ Age:_____ Patient Soc. Sec. #_____
Employer:_____ Occupation:_____
Family Physician:_____ Referred By:_____
Emergency Contact / Telephone Number:_____
May we contact you via email? Email Address:_____

RESPONSIBLE PARTY

(If different from patient)

Name of Responsible Party:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____
Relationship to Patient:_____

INSURANCE

Medical Insurance:_____	Routine Vision Ins.:_____
ID#:_____	ID#_____
Group #:_____	Group #:_____
Insured's Name:_____	Insured's Name:_____
Insured's DOB:_____	Insured's DOB:_____
Insured's SSN:_____	Insured's SSN:_____
Patients's Relationship to Insured: _____	Patient's Relationship to Insured:_____

If you have a secondary insurance, it is your responsibility to file for any benefits you may have other than Medicare / Medigap plans.

EXPLANATION OF DOCTOR'S FINANCIAL POLICY

Our office will only bill insurance companies for which we are a participating provider. Also, billing insurance does NOT guarantee payment of services. **Any insurance balance left unpaid is the patient's responsibility.** For those whose insurance we do not accept, we will supply the patient with an itemized receipt for patient re-imbursement. **Most misunderstandings about insurance can be avoided if you understand your coverage and provide our office with up-to-date insurance and personal information. Payment of services, INCLUDING CO-PAYS, is expected at the time of service from ALL patients unless prior arrangements have been made.**

SIGNATURE:_____ DATE:_____

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY STATEMENT

I, the undersigned, hereby authorize payment of vision, medical and surgical benefits directly to Dr. Harrison.
I, the undersigned, have read the above and understand that all vision, medical and surgical charges incurred by myself or my dependents for services rendered by Dr. Harrison are my financial responsibility. All court fees, attorney's fees or other fees necessary to collect this account are payable to Dr. Harrison.

SIGNATURE:_____ DATE:_____

MEDICAL HISTORY

What is your general health?_____

(Please answer each item: **Yes or No** where indicated)

Do you have problems with any of these systems?

Gastrointestinal	Y / N	Nervous	Y / N	Eyes	Y / N
Ears/Nose/Throat	Y / N	Endocrine (glands)	Y / N	Mental	Y / N
Musculoskeletal	Y / N	Blood / Lymph	Y / N	Allergic / Immunologic	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Cardiovascular (blood pressure)	Y / N

Please explain: _____

(Please answer each item: **Yes or No** where indicated)

Diabetes Y / N Type: _____ Date of Diagnosis: _____
Allergies Y / N Allergic to What?_____ Reaction?_____
Medication Allergy Y / N Reaction?_____
Headaches? Y / N Location?_____
Other health problems? Explain:_____
Current Medication(s): _____
Have you had any operations? Y / N Kind?_____ When?_____
Do you use cigarettes / tobacco? Y / N Alcohol? Y / N Other substance(s)? Y / N

FAMILY HISTORY

(Please answer each item: **Yes or No** where indicated)

High Blood Pressure Y / N Relation: _____ Macular Degeneration Y / N Relation: _____
Diabetes Y / N Relation: _____ Retinal Detachment Y / N Relation: _____
Glaucoma Y / N Relation: _____ Cataracts Y / N Relation: _____
Other eye condition(s) Y / N What kind? _____

PERSONAL EYE INFORMATION

(Please answer each item: **Yes or No** where indicated)

Have you had any eye operations? Y / N Type: _____ Date: _____
Have you had an eye injury? Y / N Kind: _____ Date: _____
Do you have glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Blurred Vision? Y / N
Other eye problems? Y / N What kind? _____
Do you wear glasses? Y / N Age of current glasses? _____ Date of last exam? _____
Do you wear contacts? Y / N Type: _____ Age of current contact lenses? _____
Do you sleep or nap in your contact lenses? Y / N What type of cleaning solution(s) do you use? _____
How many hours per day do you wear your corrective lenses? (glasses or contacts) _____

SIGNATURE: _____ DATE: _____

BRET W. HARRISON, O.D.