VISION SOURCE™

Harrison Eye Clinic, PC
Michelle Harrison, OD

Patient's name (as it appears on your insurance card)_____

Address _____ City_____ Zip_____

Social Security_____ Cell #_____ Home #_____ Preferred Contact # ☐ Home ☐ Cell

E-mail (please provide if you have one)_____ Date of Birth _____

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ married ☐ divorced ☐ widowed

Occupation: _____ Employer: _____

Emergency Contact Person: _____ Relationship_____ Phone _____

Visual History

Briefly describe the main reason for having an exam today: _____

Do you have any other symptoms related to this: _____

I currently wear glasses: ☐ full time ☐ part time

I currently wear contacts: ☐ full time ☐ part time

Please list all eye drops you use (OTC and RX)?_____ How often used? _____

Do you have a history of OR are you currently experiencing the following? CHECK THE BOXES THAT APPLY.

- ☐ Blindness
- ☐ Eye turn
- ☐ Lazy eye
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Headaches
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eyes hurt or tied
- ☐ Floaters
- ☐ Flashing lights
- ☐ Eyes feel sandy/gritty
- ☐ Halos around lights
- ☐ Bothered by light/sun
- ☐ Frequent styes
- ☐ Eyes frequently red
- ☐ Eyes itch
- ☐ Eyes burn
- ☐ Eyes tear
- ☐ Eyes feel dry

Other eye disease or condition:_____ Describe any eye injuries:_____

List any eye surgeries:_____

How many hours a day do you use a computer:_____ Describe any visual symptoms from computer use:_____

Medical History

Primary Care Physician: _____

Last Visit Date: _____ Height_____ Weight_____

List all medications you are currently taking (including OTC and vitamins) _____

_____

List any medications you are allergic to: _____

What Pharmacy do you use? _____

Are you pregnant or nursing? Y or N If yes, what is the birth or due date? _____

Do you have or ever had any CHRONIC problems in the following areas? Check the boxes that apply.

- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Diabetes
  - ☐ Insulin ☐ Non-Insulin
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Cancer

Family History

___ Family history unknown *Any history of the following in any family members (parents, grandparents, siblings, children)?

	Relationship to Patient		Relationship to Patient
☐ Poor vision	_____	☐ Cancer	_____
☐ Blindness	_____	☐ Diabetes	_____
☐ Eye turn	_____	☐ High blood pressure	_____
☐ Lazy eye	_____	☐ Stroke	_____
☐ Glaucoma	_____	☐ Thyroid	_____
☐ Cataracts	_____	☐ Other inherited disease	
☐ Macular Degeneration	_____	If yes, what disease?	_____
☐ Retinal Detachment	_____		

Social History **(confidential)**

How often do you smoke or use tobacco Products? ☐ Never ☐ Former ☐ Occasionally ☐ Daily

How often do you consume alcohol? ☐ Never ☐ Former ☐ Occasionally ☐ Daily

Do you have? ☐ Hepatitis ☐ HIV

Who referred you to our office, or how did you hear about us? _____

Insurance

Insurance: Vision _____ Primary_____ Secondary_____ Tertiary_____

Subscriber's Name _____ Date of Birth _____ SS#_____

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I understand that I am responsible for any services offered by Dr. Michelle Harrison that are not covered by my insurance. I understand that payment must be made at the time of service, including copayments, coinsurance, and deductibles. For Medicare/Medicaid recipients, Medicare/Medicaid does not cover the $25.00 refraction fee. There will be a $35.00 service charge for any returned checks.

I understand that if my account has a balance that is PAST DUE, it will be collected prior to being seen by the doctor or my appointment will be rescheduled after payment is received.

Signature: _____ Date:_____

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

AND CONSENT FOR SERVICES

I understand that payment for professional services is due at the time of checkout. Payment is required for glasses and/or contacts *prior* to processing the order. I understand that if my insurance plan does not cover the $25.00 refraction fee I am responsible for this charge. Claims will be submitted to *accepted* insurance plans. I am obligated to pay any co-pays, deductibles and remaining balances not covered or reimbursed by insurance. I understand that there will be a $35.00 service charge for any returned checks.

I consent to ocular health treatment for myself and/or on behalf of the patient for which this information pertains. I give permission for the doctor to examine, diagnose, and treat with follow up care as deemed necessary. I further attest that if signing for a minor or disabled person, I am the parent, legal guardian, or legal representative and have authority to authorize care and treatment.

ABOUT YOUR INSURANCE

There are two types of health insurance (vision and medical) that will help pay for your eye care services and products. You may have both and our practice accepts both. If you have both types of health insurance it may be necessary for Dr. Harrison to bill some services to your vision and some services to your medical insurance. We will try to obtain advanced authorization of your insurance benefits prior to your appointment; however, IT IS YOUR RESPONSIBILITY to know what benefits your insurance covers.

Vision

- Only covers routine eye exams along with eyeglasses (frames and/or lens) and contact lenses. They do NOT cover diagnosis, management or treatment of eye diseases.

Medical

- Must be used if you have any eye health problem or systemic health problem that has ocular complications. Dr. Michelle Harrison will determine if these conditions apply to you.

I understand that in an attempt to protect the privacy of my identifiable health information, Harrison Eye Clinic has established a PRIVACY POLICY and guidelines for Private Practices within our office. This information details the use/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA REGULATION, a copy of the Harrison Eye Clinic Privacy Policy and Practices has been made available to me while in the office today. Should I choose to have a personal copy; one will be given to me at no charge.

- ☐ **I understand and acknowledge the Privacy Policy and Practices of Harrison Eye Clinic.**
- ☐ **I have elected not to read the Privacy Policy and Practices of Harrison Eye Clinic.**
- ☐ **I have given Harrison Eye Clinic permission to use my email address.**

Signature_____ **Date**_____