WELCOME TO HARRIS OPTICIANS

Reason for today's visit:_____
How did you hear about us? _____

PERSONAL INFORMATION

Name Dr Mr Mrs Ms: _____Nickname: _____

Date of Birth:_____ Social Security #:_____

Address: _____ City/State/Zip:_____

Phone number (Home or Cell):_____ email:_____

Occupation: _____ Hobbies: _____

Parent/Legal Guardian:_____

INSURANCE INFORMATION

Primary **VISION** Plan: _____ ID#_____

Policy Holder Name:_____ Policy Holder SS #(last 4) _____DOB:_____

Secondary **VISION** Plan Name: _____ ID#_____

Primary **MEDICAL** Insurance:_____ ID#_____

Policy Holder Name:_____ Policy Holder SS # _____DOB:_____

Secondary **MEDICAL** Insurance:_____ ID# _____

*Any deductibles and/or copayments must be paid at the time of visit. We accept cash, check, Visa, Mastercard, Discover. Ask us about **Care Credit** today!

PERSONAL EYE HISTORY

CHECK ALL THAT APPLY:

Glasses:	**Contact Lenses:**	**Eye Conditions:**	
____I do not wear glasses	____I do not wear contacts	___ Injuries	____Amblyopia
____Distance/Driving only	____I would like to try contacts	___Glaucoma	___Eye Surgery
____Near/Reading only	____Daily Wear ____Overnight wear	___Cataracts	____ diabetic retinopathy
____Full Time	Current brand:	___Macular degeneration	Other: _____
Age of current glasses:_____	I replace my contacts every:_____	___Retinal detachments	

Prior Eyecare provider:_____ Last eye exam: _____
Prior Eye Surgeries:_____ List of current eye medications:_____

CHECK ALL THAT APPLY:

PERSONAL HEALTH HISTORY						
	YES	**NO**			**YES**	**NO**
Diabetes			type 1 or type 2	**Migraines**		
Hypertension				**Acid Reflux**		
High Cholesterol				**Arthritis**		
Heart Disease				**Respiratory**		
Cancer				**Allergies**		
Thyroid			high or low			
Strokes				**Other:**		

Do you smoke cigarettes / marijuana? No / Former smoker / Yes, _____ amount per day
Do you drink alcohol? No / Yes, _____ drinks per week
List of current medications:_____
_____
Are you allergic to any medications? No / Yes:_____

FAMILY HEALTH HISTORY				
	Father	Mother	Sister	Brother
Cancer				
Type 1 Diabetes				
Type 2 Diabetes				
High Blood Pressure				
Hypothyroid (low)				
Hyperthyroid (high)				

FAMILY OCULAR HISTORY					
	Grandparent	Father	Mother	Sister	Brother
Glaucoma					
Macular Degeneration					
Cataracts					
Other:					