

Dr. K. Norman Sawyer OD

WELCOME TO THE OFFICE

Today's Date _____
 Last _____ First _____ MI _____
 Street _____
 City _____ State _____ Zip Code _____
 Home Phone _____
 Work Phone _____
 Patient's SSN _____
 Employer (or School) _____
 Occupation (or Grade) _____
 Date of Birth _____ Age _____ Sex M F
 Spouse (or Parent's Name) _____
 Spouse (or Parent's Work) _____
 Email Address _____
 What is the major purpose of this visit? _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____
 If not referred, how did you choose our office for your needs?
 Another Dr. Insurance List
 Saw Sign/Building Newspaper/Radio/TV
 Yellow Pages: Which directory? _____
 Web Page: Which Web Site? _____
 Other _____

Insurance Information

Vision Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____
Primary Medical Insurance _____
 Subscriber Name _____
 Subscriber SSN _____
 Subscriber Birth Date _____

I authorize release of any information concerning me or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature _____

Date _____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

Blindness	<input type="checkbox"/>	Relationship _____
Cataracts	<input type="checkbox"/>	_____
Corneal Problems	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____
 Town _____
 Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) _____

Allergies to Medications: Yes No

Have you ever been diagnosed or treated for the following?

<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney	_____
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Nerves	_____

Date of Last Eye Exam _____

Patient Eye History

Do you 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 family members in need of eye care?

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?

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Iritis/Uveitis
<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Lazy Eye
<input type="checkbox"/> Eye infection	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Eye injury	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other eye disorders

Do you experience or have you ever experienced?

<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Flash of light	<input type="checkbox"/> Sunlight Sensitivity
<input type="checkbox"/> Burning	<input type="checkbox"/> Floater/spots	<input type="checkbox"/> Crossed eye/eye turn
<input type="checkbox"/> Tearing	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Trouble seeing at night
<input type="checkbox"/> Headaches	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Uncomfortable glasses
<input type="checkbox"/> Double vision	<input type="checkbox"/> Occasional dryness	

(OVER)

HIPPA PRIVACY

Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services/products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use of the vision services and products that I have received from the Location.

Patient's Signature or Patient's Representative

Date