



Gary Searce, OD • 449 E. Summit St • Crown Point, IN 46307

*Look Good & See Well*

**WELCOME TO OUR OFFICE**

Today's date \_\_\_\_\_ What is the major purpose of this visit? \_\_\_\_\_

Any problems with your present glasses or contacts? \_\_\_\_\_

**PERSONAL INFORMATION** (please print)

What do you prefer

Name \_\_\_\_\_ to be called? \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Occupation \_\_\_\_\_

Vision insur. \_\_\_\_\_ Health insur. \_\_\_\_\_ Employer \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Married? \_\_\_\_\_ Email (won't be shared) \_\_\_\_\_

Spouse's name \_\_\_\_\_ {Insured member's SSN \_\_\_\_\_ Insured's birth date \_\_\_\_\_}

Family physician \_\_\_\_\_ City \_\_\_\_\_

<p><b>MEDICAL HISTORY</b></p> <p><input type="checkbox"/> Eye injury</p> <p><input type="checkbox"/> Eye surgery</p> <p><input type="checkbox"/> Lazy eye</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Macular degeneration</p> <p><input type="checkbox"/> Retinal detachment</p> <p>Medications (Rx &amp; OTC) _____</p> <p>Allergies _____</p>	<p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Skin/ tissue disorder</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Nerve disease</p> <p><input type="checkbox"/> Blood disease</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Ear/ nose/ throat</p>	<p><b>DO YOU .....</b></p> <p><input type="checkbox"/> work at a computer for long periods?</p> <p><input type="checkbox"/> have more than one pair of glasses? (Backup glasses)</p> <p><input type="checkbox"/> spend time outdoors? (How much? _____ hrs/week)</p> <p><input type="checkbox"/> have prescription sunglasses?</p> <p><input type="checkbox"/> have problems with glare, especially while night driving?</p> <p><input type="checkbox"/> have any interest in refractive surgery?</p> <p><input type="checkbox"/> have any interest in contact lenses?</p> <p><input type="checkbox"/> wear/ have you worn contact lenses?</p> <p style="padding-left: 40px;">What kind/ brand? _____</p> <p><input type="checkbox"/> have family members in need of eyecare?</p>
<p><b>FAMILY EYE HEALTH HISTORY</b></p> <p style="text-align: right;"><i>(relationship)</i></p> <p><input type="checkbox"/> Blindness _____</p> <p><input type="checkbox"/> Cataracts _____</p> <p><input type="checkbox"/> Glaucoma _____</p> <p><input type="checkbox"/> Macular degen. _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> _____ _____</p>	<p><b>DO YOU EXPERIENCE....</b></p> <p><input type="checkbox"/> blurry distance vision</p> <p><input type="checkbox"/> blurry near vision</p> <p><input type="checkbox"/> eye strain</p> <p><input type="checkbox"/> headaches</p> <p><input type="checkbox"/> double vision</p> <p><input type="checkbox"/> trouble seeing @ night</p> <p><input type="checkbox"/> sensitivity to light</p> <p><input type="checkbox"/> glare or reflections</p> <p><input type="checkbox"/> uncomfortable glasses</p> <p><input type="checkbox"/> uncomfortable contacts</p> <p><input type="checkbox"/> _____</p>	<p><input type="checkbox"/> itching eyes</p> <p><input type="checkbox"/> burning</p> <p><input type="checkbox"/> excessive tearing</p> <p><input type="checkbox"/> gritty feeling</p> <p><input type="checkbox"/> dry eyes</p> <p><input type="checkbox"/> discharge/ goopy eyes</p> <p><input type="checkbox"/> crusty eyelids</p> <p><input type="checkbox"/> sudden loss of vision</p> <p><input type="checkbox"/> spots or floaters</p> <p><input type="checkbox"/> flashes of light</p> <p><input type="checkbox"/> nausea</p> <p><input type="checkbox"/> _____</p>

How did you first hear about our office?  Referred by friend or relative? Who can we thank? \_\_\_\_\_  
 Another healthcare provider  Vision insurance plan  Internet  Yellow pages  other \_\_\_\_\_

How will you settle your account today?  cash  credit card  debit card  check  
*Payment for services is expected at the time of service. Materials may be ordered with half down and balance on pickup. We will file your insurance as a service but the final responsibility rests with you. A service fee will be charged for non-sufficient funds checks. Should a collection agency be necessary, then collection fees will be added. We do not bill non-custodial parents.*

**I agree to these terms (signature)** \_\_\_\_\_