



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

Look Good & See Well

WELCOME BACK 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>MEDICAL HISTORY</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><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>DO YOU</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? What kind/ brand? _____</p> <p><input type="checkbox"/> have family members in need of eyecare?</p>	
<p>Medications (Rx & OTC) _____</p> <p>_____</p> <p>_____</p>		<p>DO YOU EXPERIENCE....</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>
<p>FAMILY EYE HEALTH HISTORY (relationship)</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>			

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) _____