PATIENT INFORMATION

Guarantor/Responsible Person:_____ Today's Date: ____/____/____

Patient's Name: _____M___F_____
First Middle Initial Last

Address: _____
Street City State Zip

Home Telephone: (_____) _____ SSN #:_____ - _____ - _____ Patient DOB: ____/____/_____

Cell Phone: (_____) _____ Patient's Spouse's Name: _____

Patient's Spouse's Employer: _____ Patient's Spouse's DOB: ____/____/_____

Where do you prefer to receive telephone calls? _____ Home _____ Cell

May we leave messages on your home/cell voicemail? _____

Primary Vision Insurance: _____Primary Insured's ID#_____

Primary Insured's Name: _____Primary Insured's Date of Birth ____/____/_____

Secondary Vision Insurance: _____Secondary Insured's ID#_____

Secondary Insured's Name: _____Secondary Insured's Date of Birth ____/____/_____

Medical Insurance:_____

Primary Care Medical Doctor: _____

AUTHORIZATION AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I reviewed or received at my request a copy of Sparta Optometry's Notice of Privacy Practices.

I authorized David R. Harkema OD, or any other staff person to discuss my medical information with:

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient/Legal Representative Signature_____ **Date**_____

Medical History Questionnaire

Women - Are you pregnant and/or nursing? _ No _ Yes

Everyone:

Are you an Epileptic or have sensitivity to flashes of light? _ No _ Yes

Do you have any allergies to medications? _ No _ Yes. If yes, explain: _____

List any medications you take (including contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries, and or any hospitalizations you have had.

_____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, Eye infections or eye injury:

_____

Last Eye Exam: ____/____/_____

Do you wear glasses? _ No _ Yes If yes, how old is your present pair of glasses?_____

Do you wear contact lenses? _ No _ Yes If yes, how old is your present pair of lenses?_____

Type of contact lenses:_ Rigid _ Soft _ Extended Wear _ Other Are they comfortable? _ Yes _ No

FAMILY HISTORY

Please note any family history (parents, grandparents, sibling, children; living or deceased) for the following conditions;

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	_	_	_	_____
Cataract	_	_	_	_____
Crossed Eyes	_	_	_	_____
Glaucoma	_	_	_	_____
Macular Degeneration	_	_	_	_____
Retinal Detachment/Disease	_	_	_	_____
Arthritis	_	_	_	_____
Cancer	_	_	_	_____
Diabetes	_	_	_	_____
Heart Disease	_	_	_	_____
High Blood Pressure	_	_	_	_____
Kidney Disease	_	_	_	_____
Lupus	_	_	_	_____
Thyroid Disease	_	_	_	_____
Other _____	_	_	_	_____

PLEASE TURN OVER AND COMPLETE PAGE 2

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. _ Yes, I would prefer to discuss my Social History information directly with the doctor.

Do you drive? _ No _ Yes If yes, do you have visual difficulty when driving? _ No _ Yes If yes, please describe:

_____

Do you use tobacco products? _ No _ Yes If yes, type/amount/how long: _____

Do you drink alcohol? _ No _ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? _ No _ Yes If yes, type/amount/how long: _____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas?

SYSTEM:	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	_	_	_
INTEGUMENTARY (Skin)	_	_	_
NEUROLOGICAL			
Headaches	_	_	_
Migraines	_	_	_
Seizures	_	_	_
EYES			
Loss of Vision	_	_	_
Blurred Vision	_	_	_
Distorted Vision/Halos	_	_	_
Loss of Side Vision	_	_	_
Double Vision	_	_	_
Dryness	_	_	_
Mucous Discharge	_	_	_
Redness	_	_	_
Sandy or Gritty Feeling	_	_	_
Itching	_	_	_
Burning	_	_	_
Foreign Body Sensation	_	_	_
Excess Tearing/Watering	_	_	_
Glare/Light Sensitivity	_	_	_
Eye Pain or Soreness	_	_	_
Chronic Infection of Eye or Lid	_	_	_
Sties or Chalazion	_	_	_
Flashes/Floaters in Vision	_	_	_
Tired Eyes	_	_	_
ENDOCRINE			
Thyroid/Other Glands	_	_	_

SYSTEM:	NO	YES	?
EARS / NOSE / MOUTH / THROAT			
Allergies/Hay Fever	_	_	_
Sinus Congestion	_	_	_
Runny Nose	_	_	_
Post-Nasal Drip	_	_	_
Chronic Cough	_	_	_
Dry Throat/Mouth	_	_	_
RESPIRATORY			
Asthma	_	_	_
Chronic Bronchitis	_	_	_
Emphysema	_	_	_
VASCULAR / CARDIOVASULAR			
Diabetes	_	_	_
Heart Pain	_	_	_
High Blood Pressure	_	_	_
Vascular Disease	_	_	_
GASTROINTESTINAL			
Diarrhea	_	_	_
Constipation	_	_	_
GENITOURINARY			
Genitals/Kidney/Bladder	_	_	_
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	_	_	_
Muscle Pain	_	_	_
Joint Pain	_	_	_
LYMPHATIC / HEMATOLOGIC			
Anemia	_	_	_
ALLERGIC / IMMUNOLOGIC	_	_	_
PSYCHIATRIC	_	_	_

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

Doctor's Signature: _____ Date: _____