Cell: _____ Email: _____

BOURSE OPTICAL BOUTIQUE

DR. JOHN K. GREGORY
OPTOMETRIST

NEW PATIENT QUESTIONNAIRE

PLEASE TAKE A FEW MINUTES TO COMPLETE THIS FORM SO THAT WE HAVE A BETTER UNDERSTANDING OF YOUR EYECARE NEEDS. THANK YOU.

(Circle Title) Miss Mrs. Mr. Dr. Rev. Sister

Patient Name:_____ Patient Date of Birth:_____ Age: _____

Patient Address: _____ Primary Phone:_____

_____ Alternate Phone:_____

City:_____ State:_____ Zip: _____

Employer: _____ Job Title: _____ Work Phone: _____

If Minor, Father's Name: _____ Mother's Name: _____ Grade: _____

Responsible Party (if other than self):_____

Referred By: (circle one) Relative Friend Phone Book Doctor Insurance Other

Name of Person Who Referred You:_____

INSURANCE INFORMATION

Do you have vision insurance? Yes No If Yes, Carrier and Policy #: _____

Major Medical Insurance Carrier: _____

All fees are due at the time of service. This office does not bill for professional services.

Please circle method of payment for today's professional services:

Cash Check Visa MasterCard Discover

I hereby authorize Bourse Optical Boutique to release any information I provide or that is acquired in the course of my examination to my insurance company. I also authorize payment directly from an insurance company to Bourse Optical Boutique, if applicable. This information will be kept confidential and will not be released to anyone except my insurance carrier. I acknowledge responsibility for payment of fees for all services rendered regardless of any insurance coverage including those that my insurance company does not pay. Bourse Optical Boutique will not be responsible for claim denials by my insurance company. I agree my signature will be kept on file and authorize its use for processing of future insurance claims. I acknowledge that I have received a copy of "Notice of Privacy Practices."

Signature: _____ Date:_____

(over)

PATIENT HEALTH & VISUAL INFORMATION
GENERAL HEALTH INFORMATION

Name of Physician: _____ Physician Phone Number: _____

How is your health? (please circle one) Excellent Good Fair Poor

Date of Last Physical? _____

Do you have:	Asthma?	Y	N	High Blood Pressure?	Y	N	_____ Years
	Sinusitis?	Y	N	Low Blood Pressure?	Y	N	
	Arthritis?	Y	N	Diabetes?	Y	N	_____ Years
	Headaches?	Y	N	Thyroid Disease?	Y	N	
	Pregnancy?	Y	N	Heart Problems?	Y	N	
	Lupus?	Y	N	Liver Disease?	Y	N	
	Dizziness?	Y	N	Kidney Disease?	Y	N	
	Anemia?	Y	N	Hearing Problems?	Y	N	
	Seasonal Allergies?	Y	N				

Any other health problems or changes? Y N List: _____

Been in the hospital overnight last 2 years? Y N Why? _____

Current medications (including non prescription): _____

Allergies to any medication? Y N List: _____

VISUAL INFORMATION

Date of Last Eye Examination and Doctors Name: _____

Reason for Today's Visit: _____

Do You Currently Wear Glasses? Y N How Old Are They? _____

When Do You Wear Your Glasses? Fulltime Near Only Distance Only Other: _____

Do you plan on replacing your glasses today? Y N Not Sure

Do You Wear Contact Lenses? Y N What Kind Of Contacts? Soft Gas Perm Hard

Do You Sleep In Your Contacts? Y N How Often? _____

How Old Are Your Contacts?_____ How Often Do You Throw Away Your Contacts? _____

If You Do Not Wear Contact Lenses, Do You Wish To? Y N

Do you have:	Double Vision?	Y	N	Redness?	Y	N	Discharge?	Y	N
	Blindness?	Y	N	Floaters?	Y	N	Glaucoma?	Y	N
	Eye Strain?	Y	N	Flashes?	Y	N	Lazy Eye?	Y	N
	Cross Eyed?	Y	N	Pain?	Y	N	Burning?	Y	N
	Squinting?	Y	N	Itching?	Y	N	Watering?	Y	N
	Light Sensitivity?	Y	N	Cataracts?	Y	N	Halos?	Y	N
	Macular Degeneration?	Y	N	Eye Drops?	Y	N			

Are you interested in laser surgery? Y N Maybe

Have you ever had any eye injuries or surgeries? Y N List: _____

Any other eye problems or concerns we should be aware of? Y N List: _____

List Hobbies and Interests: _____

Does any blood relative have any of the following? (circle)

High Blood Pressure Diabetes Glaucoma Macular Degeneration Other Eye Diseases