Cell:	Email: _
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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.

Patient Name	(Circle Title)	Miss	Mrs.	Mr.	Dr.	Rev.	Sister
Alternate Phone: Gity:	Patient Name:_	- 			Patient Dat	e of Birth:	Age:
Employer: Job Title: Work Phone: If Minor, Facher'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, Cerrier 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 only examination to my insurance company. I also authorize payment directly from an insurance company to Bours 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 foliam denials by my insurance compeny. I agree my signature will be kept on file and authorize its use for processin of future insurance claims. I acknowledge that I have received a copy of 'Notice of Privacy Practices.''	Patient Address	S:			Prir	mary Phone:	
Employer: Job Title: Work Phone:					Alte	ernate Phone:	
Referred By: (circle one) Relative Friend Phone Book Doctor Insurance Other Name of Person Who Referred You: INSURANCE INFORMATION	City:			St	ate:	Zip:	
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 #: 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 the 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 future insurance claims. I acknowledge that I have received a copy of "Notice of Privacy Practices."	Employer:			Job Title:		Work Phone:	
Referred By: (circle one) Relative Friend Phone Book : Doctor Insurance Other Name of Person Who Referred You: INSURANCE INFORMATION	If Minor, Father	's Name:		Mother's Name:			Grade:
INSURANCE INFORMATION Do you have vision insurance? Yes No If Yes, Carrier and Policy #:	Responsible Pa	rty (if other th	nan self):				
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."	Referred By: (ci	rcle one)	Relative	Friend	Phone Book	Doctor	Insurance Other
INSURANCE INFORMATION Do you have vision insurance? Yes No If Yes, Carrier and Policy #:	Name of Person	n Who Referre	d You:				
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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."	Do you have vi	sion insurance	? Yes No	o If Yes, Carr	ier and Policy #: .		
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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."	A	All fees are due	e at the time o	of service. This	office does not	bill for professio	nal services.
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Signature:	my examination Optical Boutique insurance carried coverage include claim denials by	n to my insura ue, if applicable er. I acknowled ing those that y my insurance	ance company. This informating responsibility my insurance of company. Ta	I also authoriz tion will be kept ty for payment company does r agree my signati	e payment direct confidential and of fees for all sernot pay. Bourse will be kept o	tly from an insu will not be releavices rendered in Optical Boutique on file and auth	urance company to Bourse ased to anyone except my regardless of any insurance will not be responsible for orize its use for processing
	Signature:		·)ate:

PATIENT HEALTH & VISUAL INFORMATION GENERAL HEALTH INFORMATION

How is your he	110/1							
How is your health? (please circle one)			Excellent	Good Fair	Poor			
Date of Last P	hysical?							_
Do you have:		Υ	Ν	High Blood Pressure		Ν		Years
	Sinusitis?	Υ	Ν	Low Blood Pressure	? Y	Ν		
	Arthritis?	Υ	Ν	Diabetes?	Υ	Ν		Years
	Headaches?	Y	Ν	Thyroid Disease?	Υ	Ν		
	Pregnancy?	Υ	Ν	Heart Problems?	Υ	Ν		
	Lupus?	Υ	Ν	Liver Disease?	Υ	N		
	Dizziness?	Υ	Ν	Kidney Disease?	Υ	N		
	Anemia?	Y	Ν	Hearing Problems?	Y	Ν		
	Seasonal Allergies?	Υ	Ν					
Any other heal	th problems or changes	s?	Y N L	ist:				
	spital overnight last 2 y							
	ations (including non pre							
	medication? Y							
			VISUAL INF	ORMATION				
Date of Last E	iye Examination and Do	ctors	Name:					
Reason for Tod	day's Visit:							
Do You Current	tly Wear Glasses? Y	Ν	How Old Ar	re They?				
When Do You	Wear Your Glasses?	Fullti	me Near On	ly Distance Only	Other: _	<u></u>		
Do you plan or	n replacing your glasses	toda	y? Y N	Not Sure				
Do You Wear C	Contact Lenses? Y	N	What Kind C	of Contacts? Soft	Gas Pe	rm Hard		
Do You Sleep Ir	n Your Contacts? Y	N	How Often	?				
How Old Are You	our Contacts?		Но	w Often Do You Thro	w Away Yo	our Contact	s? _	
If You Do Not '	Wear Contact Lenses, [oY oC	u Wish To?	Y N				
Do you have:	Double Vision?	Y	N F	Redness? Y N		Discharge?	Υ	Ν
	Blindness?	Υ	N F	Toaters? Y N		Glaucoma?	Υ	Ν
1	Eye Strain?	Υ	N F	Tashes? Y N		Lazy Eye?	Υ	Ν
	Cross Eyed?	Y	N F	Pain? Y N		Burning?	Υ	N
	Squinting?	Υ	N It	tching? Y N		Watering?	Υ	Ν
1	Light Sensitivity?	Υ	N	Cataracts? Y N		Halos?	Υ	Ν
1	Macular Degeneration?	Υ	N E	Eye Drops? Y N				
Are voll interes	sted in laser surgery?	Υ	N Maybe					
	had any eye injuries or		-	N List:				
	problems or concerns v	-		10.00				
	nd Interests: d relative have any of t							
Does any blook	essure Diabetes		Glaucoma	Macular Dege				