# Welcome To Our Office

Welcome to Harmon's Opticians! Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Name _____ Date of Birth ____/_____/_____

Address _____ ☐ Male ☐ Female

City _____ State _____ Zip Code _____

Cell Phone (___) _____-_____ Home Phone (___) _____-_____ Work Phone (___) _____-_____

E-Mail Address _____

How were you referred to our office? _____

---

**VISION INSURANCE**

**Do you have vision insurance?** ☐ Yes ☐ No If yes, please complete this section:

Primary Vision Insurance (circle one): Eyemed Physicians Eyecare Plan Cigna Other:_____

Primary Member Name _____ Member ID _____

Primary Member Date of Birth _____/_____/_____ Patient Relationship to Primary Member:

☐Self ☐Spouse ☐Child ☐Other

---

**PART ONE- Optical Questionnaire**

**Do you currently wear glasses?** ☐ Yes ☐ No Do you wear sunglasses? ☐ Yes ☐ No

Do you have visual difficulty while driving? ☐ Yes ☐ No Do you have glare problems? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No Do you use a computer? ☐ Yes ☐ No

**Do you have any specific eyewear needs such as:**

☐ Computer (custom prescription, anti-glare, tints or coatings) ☐ Special Interest (Piano, Sewing, Reading)

☐ Safety (construction, mechanics, plumbing, welding) ☐ Sports/Hobbies (motorcycle, shooting, hunting, fishing)

**Do you wear contact lenses?** ☐ Yes ☐ No If yes, which brand? _____

---

**PART TWO- Medical History**

**Please check if you have had any of the following**:

☐Glaucoma ☐Cataract ☐Macular Degeneration ☐Diabetes ☐High Blood Pressure ☐Stroke

☐Eye Injury ☐Eye Infection ☐Eye Surgery

---

I acknowledge that all of the above information is correct. I authorize Harmon's Opticians to release any information needed to secure payment from my insurance company. I understand that I am responsible for

full payment of any remaining balance not paid by my insurance company. I understand that payment is expected when services are rendered.

**Signature _____ Date ____/_____/_____**