Barry L. Harris, O.D.
901 Linwood Drive
Paragould, AR 72450

HARRIS EYE CLINIC

Family Eye Care

(870) 239-2251
(800) 320-4668 Toll Free
(870) 239-6017 Fax

PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!

Full Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____

Phone: Home _____ Business _____

Occupation _____ Employer _____

Name of Parent or Spouse _____

If Student: Grade _____ School _____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY

Name of person responsible for this account? _____ Date of Birth _____

Relationship to patient? _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

Person to contact in case of emergency? _____ Phone No. _____

INSURANCE INFORMATION

Do you have Medicare? _____ Do you have Medicaid? _____

Do you have a Medicare supplemental policy? _____

Do you have Major Medical Insurance? _____

Insurance Co. Name _____ Plan _____

Do you have Vision Care Insurance? _____

Insurance Co. Name _____ Plan _____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

WE ASK THAT YOU ALLOW US TO MAKE COPIES OF YOUR INSURANCE CARDS.

*****Please read and sign below.*****

I have received the Notice of Privacy Practice and Patient Rights of this practice.

I acknowledge that all information on this form is accurate and up-to-date.

IT IS CUSTOMARY TO PAY FOR PROFESSIONAL SERVICES WHEN RENDERED. IF YOU DO NOT HAVE MEDICAL INSURANCE THEN ARRANGEMENTS MUST BE MADE IN ADVANCE FOR PAYMENT. WE ACCEPT ASSIGNMENT ON MEDICARE, MEDICAID, AND ARKANSAS BLUE CROSS/BLUE SHIELD. PATIENTS WILL BE RESPONSIBLE FOR ANY MEDICARE OR INSURANCE DEDUCTIVE AND THEIR CO-INSURANCE AMOUNTS.

I hereby authorize this office to furnish medical information to pay insurance carriers, including Medicare, Medicaid, and Arkansas Blue Cross/Blue Shield, and assign to Harris Eye Clinic.

Signature _____ Date _____

Phone:_____ Age:_____ Full Name: _____

Occupation:_____ Home Address: _____ Date: _____

Family Medical History: Has anyone in your family ever had any of the following:

❑ Diabetes	❑ Glaucoma	❑ Crossed/Turned Eye
❑ Tuberculosis	❑ Blindness	❑ Amblyopia/Lazy Eye
❑ High Blood Pressure	❑ Eye Disease	❑ Use Eye Drops Regularly

Medical History: Have you now or have you ever had any of the following:

❑ Surgeries	❑ Eye or Head Injuries	❑ Drug Reactions/Allergies
❑ Eye Surgeries	❑ Eye Infection/Disease	❑ Asthma
❑ Glaucoma	❑ Double Vision	❑ Diabetes

Known Medical Problems:_____

Current Medications:_____

ROS: Do you now have any diseases or conditions involving the following systems:

❑ Skin	❑ Endocrine	❑ Psychiatric
❑ Muscle/Skeleton	❑ Respiratory	❑ Neurologic
❑ Ears, Nose, Throat	❑ Gastrointestinal	❑ Blood/Circulatory
❑ Heart, Cardiovascular	❑ Allergic/Immunologic	❑ Eyes

CC:

Distance:

Near:

HPI: Onset Severity Assoc. Sympt.

Duration/Frequency Quality Location

Subjective: OD						OS				
K's: OD						OS				
#1	Type				PWR	Type				PWR
	BC	Diam.		Cent.		BC	Diam.		Cent.	
	Over Rx		20/	Un	20/	Over Rx		20/	Un	20/
#2	Type				PWR	Type				PWR
	BC	Diam.		Cent.		BC	Diam.		Cent.	
	Over Rx		20/	Un	20/	Over Rx		20/	Un	20/
#3	Type				PWR	Type				PWR
	BC	Diam.		Cent.		BC	Diam.		Cent.	
	Over Rx		20/	Un	20/	Over Rx		20/	Un	20/