Welcome to our office
Dr. Lawrence Jacobs & Dr. Karla Quinton

Patient Name _____ Date of Birth _____ Home Phone _____
Last First Middle (Male or Female)
Mailing Address _____ City _____ State ____ Zip Code _____
E-mail Address _____ Social Security # _____
Occupation _____ Firm Employed By/school _____ Cell/Daytime Phone _____
Spouse (or parent) _____ Occupation _____ Firm Employed By _____

To help our office keep more accurate records, please list any other immediate family members living at home and their ages: _____
_____
Has any member of your immediate family been a patient of Jacobs HD Eyecare Center? Please name: _____

Whom may we thank for referring you to our office or how were you referred to us? (Friend/Relative) _____
(Please specify) Yellow pages / Newspaper / Sign / Direct Mail / Insurance Company (please specify) _____
Please list your vision insurance company if you have one _____

Are you sensitive to light or glare? yes/no Do you currently wear polarized sunglasses with ultraviolet protection? yes/no
Do you use a computer more than 30 minutes a day? yes/no Do you currently wear "computer glasses"? yes/no Hours per day _____
Do you wear contact lenses now? yes/no Have you worn contact lenses? yes/no
Are you interested in more information about contact lenses? yes/no (If yes, see next page)
Are you interested in more information about Lasik eye surgery? yes/no
Are you interested in more information about CRT lenses (similar to Lasik but with contacts)? yes/no
How old are your current glasses? _____ Do you have a spare pair of glasses/contact lenses? yes/no
Approximate Date of last eye exam? _____ Doctor's name and city _____
Reason or nature of this appointment? _____

Circle any that you experience: Eye Strain, Eye Pain, Double Vision, Headaches, Dryness, Itching, Burning, Flashes coming from within your eyes, Floating Spots, Redness, Eye Secretions, Allergies in your eyes, Haloes around light, Uncomfortable reading, other:
_____

Circle your personal, general health history (past and present): Glaucoma, Diabetes, Eye Diseases, Eye Surgery, Recurring eye infections, Eye or Head injuries, Asthma, Hayfever, Seasonal allergies, High Blood Pressure, Skin conditions, Cold sores, Arthritis, Surgical operations, other: _____

Circle any that your blood relatives have or had: Glaucoma, Diabetes, Macular degeneration, Cataracts, Blindness, Crossed eyes, Colored Blindness, High blood pressure, other: _____

Are you taking any medications or vitamins that you use on a regular basis? yes/no (For females: Birth Control Pills? yes/no)
If yes, please list: _____
Have you ever had an allergic reaction to a drug? yes/no Penicillin / Sulfa / Anesthetic / Other? _____
Who is your primary physician? _____ Their location? _____

Please circle your special interests or hobbies so a better assessment of your visual needs can be made: Skiing, Boating, Fishing, Scuba Diving, Flying, Golfing, Hunting, Shooting, Hiking, Stamps, Sewing, Needlepoint, Carpentry, Metal work, Musical instruments, Racket sports, Reading, Other: _____

FINANCIAL POLICY:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered. Professional fees for services are due upon completion of examination or treatment. I hearby authorize Jacobs HD Eyecare Center doctors to treat the patient identified above. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I acknowledge that I am responsible to pay all charges for all treatments administered by the doctor to the patient identified above. I understand that insurance may not pay for all charges, and I understand that I am obligated to pay for all charges not paid by insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Thank you for allowing us to assist in your eye health care and visual needs.

Signature _____ Date _____