Charles D. Leahy, O.D., M.S.
Instructor in Ophthalmology, Harvard Medical School
Optometry, Contact Lenses

(PLEASE COMPLETE ALL ITEMS IN LEGIBLE PRINT)

Date: ___/___/____

PATIENT INFORMATION

Name: _____ Date of Birth ___/___/____ Sex: M F
Street: _____ Phone: Home: _____
City: _____ Work: _____
State: _____ Zip code: _____ Cell: _____

E-mail address: _____

Circle preferred contact for reminders, messages: e-mail phone

Primary Care Physician (PCP): _____ Address: _____

PCP Phone: _____ PCP Fax: _____

Occupation: _____ Employer: _____
Health Insurance: _____ Policy/Group Number: _____
Subscriber Name: _____ Subscriber DOB: _____
Referred by: _____
Family members treated by this office: _____
Nearest relative *not living with you* : _____
Financial responsibility (name and address if different from above): _____

AUTHORIZATION FOR TREATMENT AND PAYMENT

I hereby consent to my examination and treatment in the office of Dr. Leahy. I authorize the doctor to obtain from other hospitals and physicians, records of my medical treatment. I understand that treatment for my medical condition is strictly between the doctor and myself. I understand that the doctor's office will assist me in filling out insurance forms, and that if the insurance company does not pay for any reason, I am responsible for payment of the bill. In addition, I understand that I am responsible for any balance of the bill that the insurance company does not pay.

Vision plan patients: I understand that insurance often does not pay for "non-covered" and "not medically necessary services" and that I am responsible to pay for these services. Specifically, insurance often considers refraction and contact lens care and supplies a "non-covered" service and I will be responsible for payment.

I authorize release of any medical information necessary to process insurance claims for services rendered to me and request payments of insurance benefits for services rendered me to be paid directly to Dr. Leahy's office.

Signature of patient or parent/guardian: _____

Reason for today's visit: _____

Ocular History (List past and present information):
Record any eye related problems or injuries you have, such as "lazy eye", amblyopia, astigmatism, glaucoma, cataract, conjunctivitis, dry eye, etc., and any eye surgeries.

| Family History: | | | Relationship to Patient: |
|---|---|---|---|
| Diabetes | No ☐ | Yes ☐ | |
| Glaucoma | No ☐ | Yes ☐ | |
| High Blood Pressure | No ☐ | Yes ☐ | |
| Retinal Detachment | No ☐ | Yes ☐ | |
| Macular Degeneration | No ☐ | Yes ☐ | |
| Dry Eye | No ☐ | Yes ☐ | |

When was your last eye exam? _____ How old are your eyeglasses? _____

List, or Provide List of, Current Medications and Dose: ☐ No current meds

Allergies, including to medications, seasonal, and any treatments: ☐ No known allergies

List systemic illnesses/conditions:

List Hobbies/activities:

Computer use: ☐ <1 hr/day ☐ 1-3 hr/day ☐ 3-8 hr/day ☐ >8 hr/day

# Contact Lens Information

Type you currently wear: _(soft/rigid/other)_____

If known, brand name lens you wear: _____
How many years have you worn this type of lens: _____

Frequency of lens replacement: Prescribed:_____ Actual:_____
Hours/day wear typically: _____ Number of hours worn today: _____
Do you sleep in your lenses: No ☐ Yes ☐
If yes, how frequently? _____

Name of contact lens solutions you use: _____
Do you rub your lenses to clean them before putting in case: No ☐ Yes ☐

Any problems with lenses, such as with vision or comfort: _____
_____
_____
_____
_____

Are there specific contact lenses you have questions about? _____
_____
_____
_____

Contact Lens - History:
Summary of previous experience with contact lenses: _____
_____
_____
_____
_____
_____
_____
_____