John Barnhart, OD, Inc.
Welcome Back To Our Office

Welcome to John Barnhart, OD, Inc.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ____ MI ____ Last Name ____ Preferred Name ____

Street Address ____ City ____ State Zip ____

Social Security Number ____ Date of Birth ____ Home Phone - Include Area Code ____ Day Phone ____

Email Address ____ Guardian ____ Person Responsible for Account ____

Emergency Contact ____ Emergency Phone ____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? ____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ____ City ____ State Zip ____

M ☐ F ☐ Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company ____ City ____ State Zip ____

M ☐ F ☐ Insured's First Name ____ MI ____ Insured's Last Name ____

Insured's Identification Number ____ Group Number ____ Insured's Date of Birth ____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that Tricare-870140 will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. 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.

Signature ____ Date ____

Name

John Barnhart, OD, Inc.
MEDICAL HISTORY QUESTIONAIRE

SOCIAL HISTORY

Current Occupation : ____________________ Years ________ Employer ____________________

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? ______ Distance from Computer? ______

Do you drive? ○ Yes ○ No Mileage to work each way? _____

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since __________

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No ____________________

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Occupational (mechanics, plumbers, pilots)
☐ Safety Glasses (gardening, woodworking, welding)
☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? ______________

Do you currently wear contact lenses? ○ Yes ○ No Since ____________________

Type and brand of contact lenses ____________________ Today's wearing time ? ______

How many hours/day ? ________ How many days/week ? ______

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	____	____	Distance Vision	____	____	Near Vision	____	____

What Solutions do you use? Cleaner ______________ Disinfectant ____________ Enzyme ____________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : ____

Name

John Barnhart, OD, Inc.
PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? ____________ When was your last exam ? ________

When was your last health exam ? ________

Past Illnesses or Injuries: ____________

Past Surgeries: ____________

Current Medications: ____________

Current Eye Drops: ____________

Medicines that cause reactions or sensitivities: ____________

Specific Allergies: ____________

EYE HISTORY

Condition		Condition		Condition	
Glaucoma	O Yes O No	Dryness	O Yes O No	Strabismus (Crossed Eyes)	O Yes O No
Cataract	O Yes O No	Excess Tearing/Watering	O Yes O No	Blurred Vision Distance	O Yes O No
Macular Degeneration	O Yes O No	Eye Pain or Soreness	O Yes O No	Blurred Vision Near	O Yes O No
Retinal Detachment	O Yes O No	Foreign Body Sensation	O Yes O No	Distorted Vision (halos)	O Yes O No
Color Blindness	O Yes O No	Infection of Eye or Lid	O Yes O No	Double Vision	O Yes O No
Headaches	O Yes O No	Itching	O Yes O No	Floaters or Spots	O Yes O No
Glare/Light Sensitivity	O Yes O No	Mucous Discharge	O Yes O No	Fluctuating Vision	O Yes O No
Tired Eyes	O Yes O No	Drooping Eyelid	O Yes O No	Loss of Vision	O Yes O No
Amblyopia (Lazy Eye)	O Yes O No	Redness	O Yes O No	Loss of Side Vision	O Yes O No
Burning	O Yes O No	Sandy or Gritty Feeling	O Yes O No		

GENERAL HEALTH CONDITION

Condition		Condition		Condition	
Fever	O Yes O No	Respiratory (Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Thyroid, Diabetes	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears,Nose,Throat	O Yes O No	Muscles,Bones,Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (high blood pressure etc.)	O Yes O No	Skin	O Yes O No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	O Yes O No		

FAMILY HISTORY

Condition		Condition		Condition	
Amblyopia (Lazy Eye)	O Yes O No	Retinal Detachment	O Yes O No	High Blood Pressure	O Yes O No
Blindness	O Yes O No	Strabismus (Eye Turn)	O Yes O No	Kidney Disease	O Yes O No
Cataract(s)	O Yes O No	Arthritis	O Yes O No	Lupus	O Yes O No
Color Blindness	O Yes O No	Cancer	O Yes O No	Stroke	O Yes O No
Glaucoma	O Yes O No	Diabetes	O Yes O No	Thyroid Disease	O Yes O No
Macular Degeneration	O Yes O No	Heart Disease	O Yes O No	Others	O Yes O No