Hagen Eye Care

Date:_____/_____/_____

Patient's Name:_____ Age:_____ Date of Birth:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ Email:_____

Address:_____ City:_____ State:_____ ZipCode:_____

Occupation:_____ Employer:_____

OR if student, Name of School:_____ Grade:_____

Social Security Number: _____

Insurance Carrier:_____ Policy/ID Number:_____

Name of a Parent or Spouse:_____ Date of Birth (Guardian):_____

I authorize Hagen Eye Care to submit any information necessary to my insurance carrier for payment:

Signature:_____ Date:_____

I do not wish to have my eyes dilated at this time:

Signature:_____ Date:_____

What is your main reason for your visit today?:_____

What are your current hobbies?:_____

Are you presently being treated for any medical conditions? YES or NO

If YES, what are you being treated for?:_____

Are you presently taking any medications? YES or NO

If YES, please list medications:_____

GENERAL HEALTH (Past or Present) Check all that apply:

___allergies ___diabetes ___drug sensitivity ___eye disease ___eye or head injury

___glaucoma ___headaches ___heart disease ___high blood pressure ___seizures

___skin conditions ___tuberculosis

FAMILY HISTORY Check all that apply:

___cataracts ___diabetes ___eye disease ___glaucoma ___high blood pressure

Name of Family Physician:_____ Date of last health exam:_____

EYE CONDITIONS Check all that apply:

___distance ___near ___burning ___itching ___tearing ___light sensitivity

___twitching eye lids ___glare at night ___computer eye strain

Who may we thank for referring you to our office?:_____

Hagen Eye Care

Contact Lens Evaluation Sheet

We would like to insure all of our patients have the best contact lens wearing experience possible. In order to do so, we would appreciate you taking a few moments to complete the below questionnaire.

1. On a scale of 1 to 10, please rate your current contact lens wearing experience at the **BEGINNING** of the day.

Extremely Unsatisfied									Extremely Satisfied
○1	○2	○3	○4	○	○6	○7	○8	○9	○10

2. On a scale of 1 to 10, please rate your current contact lens wearing experience at the **END** of the day.

Extremely Unsatisfied									Extremely Satisfied
○1	○2	○3	○4	○	○6	○7	○8	○9	○10

3. If your answer above was not 10, what would make it a 10? What's missing?_____

4. How frequently do you replace your contact lenses for a new pair?_____

5. How often do you sleep in your contact lenses?
   - ○ Never
   - ○ Occasionally sleep or nap
   - ○ 1 to 3 nights per week
   - ○ Everyday
   - ○ Other _____

6. How frequently do you experience the below symptoms while wearing your contact lenses?

	Never	Sometimes	Always
Discomfort	O	O	O
Dryness	O	O	O
Deposits	O	O	O
Tired Eyes	O	O	O
Irritation	O	O	O
Redness	O	O	O

7. Would you prefer to wear contact lenses that require regular cleaning or lenses that do not need to be cleaned?
   - ○ I prefer to clean and store my contact lenses
   - ○ I would like the convenience of lenses that do not require regular cleaning

Additional comments:

❖ A contact lens fitting and/or evaluation is NOT part of a routine exam and is not usually covered by insurance.

Hagen Eye Care

A FIFTY PERCENT (50%) DEPOSIT IS REQUIRED ON ALL FRAME AND LENS ORDERS.

ALL FRAMES HAVE A ONE YEAR MANUFACTURER DEFECT WARRANTY AS OF THE DATE OF PURCHASE. THERE WILL BE A $20.00 - $25.00 REPLACEMENT FEE TO EXCHANGE THE FRAME. IF THE PATIENT DECIDES TO USE HIS/HER OWN FRAME AND IT BREAKS, WE ARE NOT RESPONSIBLE.

IF THE ORDER IS NOT PICKED UP WITHIN 30 DAYS FROM DATE OF PURCHASE, THE PATIENT WILL LOSE THEIR 50% DSEPOSIT.

SIGNATURE: _____

DATE: _____

No-Show Policy

Dear Patient,

We understand that there are legitimate reasons for having to cancel an appointment. We ask you to show consideration by calling 24 hours in advance. If your appointment is NOT cancelled 24 hours in advance there will be a **$50** non-cancellation fee that cannot be filed to your insurance.

Thank you for understanding

Name of Patient: _____

Signature: _____ Date: _____

When patient is under the age of 18 or unable to affix signature:

Name of guardian: _____

Signature of guardian: _____ Date: _____

{Hagen Eye Care}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____