THE OFFICE OF
JOHN K. HARDY, O.D., P.A.

CONFIDENTIAL PATIENT INFORMATION

_____/_____/_____ **(Date)**

PLEASE PRINT

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

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Cell Phone/Pager: _____

Work Phone: _____ Email: _____

Age: _____ Date of Birth: _____/_____/_____ SS #: _____-_____-_____ Driver's License #: _____

Occupation: _____ Spouse' Name: _____

Hobbies, Special interests: _____

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

History:

_____Diabetes	_____Hypertension	_____Dry Eye
_____Light Flashes	_____Heart Disease	_____Double Vision
_____Eye/Head Injury	_____Cataracts	_____Eye Muscle Problems
_____Glaucoma	_____Floaters	
_____Headaches	_____Lazy Eye	
_____Thyroid Disease	_____Allergies	

Other _____

_____

Medications and/or Nutritional Supplements: (List name and purpose): _____

_____

_____

_____

Are you wearing or have you ever worn or tried contact lenses? ___Yes ___No. If not, are you interested in contact lenses? _____Yes _____No

In Case of Emergency, Contact: _____ Phone: _____

Primary Care Physician: _____ Date of Last Visit: _____

Referred by: ☐ Phone Book ☐ Insurance ☐ School ☐ Drive By ☐ Advertisement ☐ Patient _____

☐ Doctor _____ ☐ Other _____

Insurance: _____

ID#: _____ Group # _____

Name of Primary Person on Insurance: _____ Date of Birth: _____

If patient is a child or adolescent, please complete the following:

Parent or Legal Guardian: _____ _____

_____Mother _____Father _____Other (please specify)_____

Cell Phone: _____ Work Phone: _____ Employer: _____

Child's School: _____ Grade: _____

INFORMED CONSENT & TREATMENT AUTHORIZATION

- I (do) ____ (do not) ____ authorize John K. Hardy, O.D., P.A., and/or his staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.
- I (do) ____ (do not) ____ authorize John K. Hardy, O.D., P.A., and/or his staff to leave a message at my place of employment.
- If you would like a copy of Privacy Practices of John K. Hardy, O.D., P.A., one is available on Hardy Eyecare. com. You may download or print one at your convenience.

I hereby authorize the release of all necessary Protected Health Information and assign all medical and vision benefits to John K. Hardy, O.D.,P.A. I request that you file my insurance but do understand that I am ultimately responsible for any bill incurred in this office.

I hereby authorize John K. Hardy, O.D., P.A., to provide a diagnosis & optometric treatment plan to me or my child. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care.

_____ _____

Patient or Legal Guardian's Signature Date