



Dr. J. Michael Harmon and Associates
 534 larkfield center, santa rosa, CA 95403 707-578-4200 fax 707-578-5622

First Name _____ Last Name _____ (MI) _____ Date of birth ____/____/____
 Address _____ City _____ Zip _____ Sex F M
 Phone: Home _____ Work _____ Cell _____ SS # _____/_____/_____
 Emergency contact _____ Relationship _____ Phone _____
 Single ___ Married ___ Domestic Partner ___ Significant Other Name _____
 Names and ages of children _____ Parent, if Patient is a child _____
 Occupation _____ Employer _____ Date of last eye exam _____
 Vision Insurance Y / N Insured Name _____ Insurance ID # _____ Referred by _____
 I would like to be notified of special events by email. Email address _____
 How did you hear about our office? friend/family Press Democrat Bohemian phone book online

Please check any of the following reasons for this exam:
 New eyeglasses Computer lenses Eye health examination Reading glasses Contact lenses
Describe your interest in Laser Vision Correction: very interested interested thought about it not interested not a candidate
 Why or why not? _____

GENERAL INFORMATION

Do you wear glasses? Y / N
 How many years? _____
 Are glasses for distance? Y / N
 Are glasses for reading? Y / N
 Do you wear contact lenses? Y / N
 What type: Soft / Hard / Daily / Disposable
 Bifocal Contacts / Colored / Extended Wear
 Do you work on a computer? Y / N
 How many hours daily? _____

To help us provide you with the best vision, please check any of the activities that apply to your lifestyle in work or pleasure.

<input type="checkbox"/> Accounting	<input type="checkbox"/> Driving	<input type="checkbox"/> Piano	<input type="checkbox"/> Team sports
<input type="checkbox"/> Bicycling	<input type="checkbox"/> Fishing	<input type="checkbox"/> Playing cards	<input type="checkbox"/> Television
<input type="checkbox"/> Computer use	<input type="checkbox"/> Flying	<input type="checkbox"/> Racquetball	<input type="checkbox"/> Tennis
<input type="checkbox"/> Crafts	<input type="checkbox"/> Gardening	<input type="checkbox"/> Reading	<input type="checkbox"/> Video games
<input type="checkbox"/> Data Entry	<input type="checkbox"/> Golf	<input type="checkbox"/> Running	<input type="checkbox"/> Water sports
<input type="checkbox"/> Desk Work	<input type="checkbox"/> Machine operator	<input type="checkbox"/> Sewing	<input type="checkbox"/> Woodworking
<input type="checkbox"/> Drafting	<input type="checkbox"/> Motorcycle riding	<input type="checkbox"/> Skiing	<input type="checkbox"/> Other:
<input type="checkbox"/> Drawing	<input type="checkbox"/> Needlework	<input type="checkbox"/> Studying	_____

Please complete all that apply regarding your MEDICAL INFORMATION

What is your general health? _____
 Current medications: _____

FAMILY MEDICAL HISTORY	YOUR MEDICAL HISTORY
High blood pressure Y / N Relation _____	High blood pressure Y / N
Diabetes Y / N Relation _____	Diabetes Y / N Type _____
Glaucoma Y / N Relation _____	Date of diagnosis _____
Macular degeneration Y / N Relation _____	Allergies Y / N Allergic to what? _____
Retinal detachment Y / N Relation _____	Medication allergy Y / N What meds? _____
Cataracts Y / N Relation _____	Headaches Y / N Dry eyes Y / N Red eyes Y / N
Other eye condition(s) Y / N Relation _____	Cataracts Y / N Glaucoma Y / N Blurred vision Y / N
What kind? _____	Other health problems? _____

I understand that if my insurance eligibility cannot be verified, or if my insurance does not pay the amount due to my account, that I will be financially responsible for payment of all charges incurred for services received from Sonoma Eyeworks and Sonoma Eyeworks Optometry.

Privacy Notice: This office's privacy practices are in accord with HIPPA regulations. You may obtain a copy of our privacy practice at any visit. Your signature here indicates that you have been advised of the availability of this information.

Authorized Signature _____ Date _____