



**DR. MARY ANNE C. MURPHY, O.D.**  
**5760 WEST 120<sup>TH</sup> AVENUE, SUITE 240**  
**BROOMFIELD, CO 80020**

***ROTC / Service Academy / Allied Health Personnel  
Vision Screening History Form***

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***Personal Information***

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Home Phone (\_\_\_\_) \_\_\_\_\_

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***Eye History***

Do you wear eyeglasses?      Yes      No  
Do you wear contact lenses?      Yes      No  
If yes, please circle which type:      Gas Permeable (hard)      Soft      CRT (nighttime reshaping)  
When was the last day and time that you had the lenses in your eyes: Day: \_\_\_\_\_ Time: \_\_\_\_\_  
Have you ever had eye surgery?      Yes      No

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***Acknowledgement***

- By signing below I acknowledge that I have been requested by the Department of Defense to appear at Front Range Eye Associates for a vision screening. However, if authorization is not confirmed, I understand that I will be responsible for all charges.
- I also understand that the services performed today are merely screening tests. They are in no way to be construed as a substitute for a comprehensive eye exam. Because the Department of Defense has ordered this screening, I understand that all information gathered becomes property of the United States government. I understand that neither the doctor nor the staff at Front Range Eye Associates can release any of this information to me.
- I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for Front Range Eye Associates and I understand how my personal information may be used.

Signature of Patient (or Responsible Party) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\* Parent must sign if child is under 18 years of age.