PATIENT INFORMATION

Date _____

Patient_____

Address_____

_____

City State ZIP

Marital Status _____ Race_____

Preferred language_____ Ethnicity_____

Sex: M F Age _____ Birthdate_____

SSN _____

Height_____ Weight_____

Home Phone # _____

Cell Phone #_____

Email Address _____

Patient Occupation_____

Patient Employer _____

Employer Telephone_____

Spouse_____

Whom may we thank for referring you?_____

Emergency contact/number_____

Family Doctor_____ Last visit_____

Last Eye Doctor_____ Last exam_____

INSURANCE

Primary Insurance_____

Secondary Insurance_____

Vision Insurance_____

Name of Insured_____

SSN of Insured _____-____-_____

Date of birth _____/_____/_____

If other than insured…

Guarantor name_____

Address_____

_____

Phone # ( ) _____-_____

SSN _____-____-_____ DOB ___/____/____

RETINAL IMAGING & DILATION

Digital retinal imaging provides instant photos of the inside of your eyes. They are used to track or diagnose abnormal eye conditions. Our fee for this service is $35.00. (Children 12 and under have no charge).

ACCEPT DECLINE SPEAK WITH DR.

Dilation allows a more thorough examination of the eye. Our doctors recommend new patients and require all diabetic patients to be dilated.

ACCEPT DECLINE SPEAK WITH DR.

AMD Risk Assessment identifies age related macular degeneration. It is recommended for all patients over 21. The cost for this test is $15.00.

ACCEPT DECLINE SPEAK WITH DR

Preferred Pharmacy:_____ Location:_____ Phone #:_____