



DOCTORS OF OPTOMETRY, INC.  
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**Patient Registration**  
*Welcome to our office*

Mr.  
 Patient's Name:  Mrs. \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Miss (First) (M.) (Last)  
 Address: \_\_\_\_\_ Approximate date of last vision exam: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Occupation/Grade: \_\_\_\_\_ Employer/School: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Marital Status (check one):  Single  Divorced  Widowed  Married Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ If Minor: Parent's Names: \_\_\_\_\_

Examination fees are due upon completion of services. A nonrefundable 50% deposit is required for all prescription orders. Fees not paid by insurance and any incurred collection fees are the responsibility of the patient.

Preferred method of payment (check one):  Cash  Check  Credit Card Do you have a Vision Plan?  Yes  No

Family member responsible for account: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_ SS#: \_\_\_\_\_

Insurance Authorization and Release/Acknowledgement of Receipt of Notice of Privacy Policies: I request that payment of authorized insurance benefits for any services furnished to me be made on my behalf to Dr. Dowd, Dr. Zanolidakis, or Dr. Hornik. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for any non-covered insurance benefits. I acknowledge that I have been given a copy of this office's notice of privacy policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The following questions will help us in your vision examination and in our recommendations to you. Please check the best answer. If you are uncertain about an answer, leave it blank. The questions pertain to your vision with your glasses or contact lenses on, whichever you usually wear.

Are you having problems with your distance vision? .....  Yes  No

Are you having problems with your near vision? .....  Yes  No

Have you ever had any eye diseases or eye injuries? .....  Yes  No

Have any of your blood relatives ever had any serious eye diseases? .....  Yes  No

Do you get more than two headaches per week? .....  Yes  No

Do you feel your health is (check one):  Good  Fair  Poor

Are you being treated for any medical conditions? .....  Yes  No

If yes, please list: \_\_\_\_\_

Are you taking any medications? .....  Yes  No

If yes, please list: \_\_\_\_\_

Prescribed by: \_\_\_\_\_ For what purpose: \_\_\_\_\_

Do you have any allergies, including medications? .....  Yes  No

If yes, please list: \_\_\_\_\_

Are your eyes sensitive to sunlight? .....  Yes  No

Do you feel the need for a spare pair of glasses? .....  Yes  No

Do you currently wear contact lenses? .....  Yes  No

If no, are you interested in wearing contact lenses? .....  Yes  No

Do you feel the need for glasses designed specifically for any hobbies, sports, or occupational needs? .....  Yes  No

Are you interested in LASIK refractive surgery if you are a candidate? .....  Yes  No

Who may we thank for referring you to our office? \_\_\_\_\_

Are there any other family members or friends in need of a vision exam at this time or in the near future? \_\_\_\_\_

Please list names: \_\_\_\_\_