Verona Opticians - Dr. Doolen & Dr. Rispoli

PATIENT REGISTRATION & MEDICAL HISTORY

We require payment in full/or insurance co-pays at the time services are rendered or eyewear is ordered. We offer a 5 % discount for paying in full at time of service when not billing insurance. We accept cash, check, Visa, Discover, and Master Card and Care Credit.

Date_____ Age_____ Birth date_____ **Email** _____

If this is your first visit to our office, how did you learn about us? Friend Family Phone Book Website Other:_____

Last Name_____ First Name_____M.I._____ Mr. Mrs. Ms. Rev. Dr.

Street_____City_____State_____Zip_____

Sex: M F Soc. Sec. #_____Employer_____Occupation_____

Cell Phone_____ Home Phone (if no cell)_____

Marital Status_____Spouse's Name & Employer _____

Insurance Information

Do you have vision insurance? Yes No Do you have health insurance? Yes No

Name of insurance company_____Policy Holder_____

Relationship to Policy Holder_____Policy Holder's Social Security no._-____-_____

Please bring both your vision and health insurance cards to your appointment.
Co-pays & deductibles are required on date of service. We will bill your insurance but can't assure payment. You are fully responsible for payment.
(*Please give your insurance forms or cards to the receptionist.*)

List any medication you are taking now – *Prescription or Over-the-Counter:*

_____

List any medication or eye drops you are allergic to: _____

_____

Please check your answers to all the questions below.

Your General Health	**Family Health History**	**Vision Needs**	**Options**
Have you ever had or do you currently have…	Has anyone in your family had….	Do you do any of the following?	Do any of the following options appeal to you? –please circle-
❑ Allergies	❑ Diabetes	❑ Crafts/Sew	Thinner/Lightweight Lenses
❑ Arthritis	❑ Glaucoma	❑ Gardening	Lenses that darken
❑ Diabetes	❑ Blindness	❑ Computer	No-line Bifocals
❑ Cancer	❑ Cataracts	❑ Read Books	Anti-Glare Treatment
❑ Headaches	❑ Crossed Eyes	❑ Golf	Contact Lenses
❑ Gastrointestinal Disease	❑ Lazy Eye	❑ Team Sports	Laser Vision Correction
❑ Drug Reaction	❑ Macular Degeneration	❑ Music	Scratch Resistant Coating
❑ Heart Disease	❑ None of the above	❑ Shooting	Sunglasses/Sunglass clips
❑ High Blood Pressure		❑ Racquet Sports	Safety glasses
❑ Thyroid Disease	**SOCIAL HISTORY**	❑ Skiing	Computer glasses
❑ Kidney Disease	Do you……..	❑ Fishing	Golfing/biking/fishing Rx
❑ Respiratory Disease	❑ Smoke	❑ Woodshop	Sports goggles
❑ Eye Disease	❑ Consume Alcohol	❑ Water Sports	TV glasses
❑ Eye Surgery	❑ Use Street Drugs	❑ None of the above	
❑ Other	❑ None of the above		
❑ None of the above			

Patient Signature_____Date_____