Welcome To The Office Of

IVOR MEYERSON O.D. F.A.A.O. M.R.S.H.

DOCTOR OF OPTOMETRY

To better serve you, please complete the following:

Name_____ Title: Prof Dr Ms Mr Mrs Other _____

Address_____ Occupation_____

City_____ State_____ SS # _____

Zip Code_____ Vision Insurance_____

Phone (home)_____ Phone (work)_____

Phone (cell) _____ Date of birth _____

Firm Employed by _____ e-mail address_____

Whom may we thank for referring you to us?

_____

If you are wearing contact lenses, who fit you with your last set?

Name_____ Address_____

Please check your preferred method of payment:

Check___ Cash___ Visa___ Master Card___ Discover___ American Express___ Care Credit___

Do you or any family member suffer from:

Heart Disease -	yes	no	High Blood Pressure -	yes	no
Glaucoma -	yes	no	Any Eye Disease -	yes	no
Diabetes -	yes	no			

EXAMINATION FEES ARE TO BE PAID ON THE DAY SERVICES ARE RECEIVED.
ALL ORDERS REQUIRE A MINIMUM DEPOSIT OF 50 %.

Authorization and release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practioners. I authorize and request my insurance company to pay directly to Dr. Ivor Meyerson insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and/or materials. I agree to be responsible for payment of all services and/or materials rendered on my behalf or my dependents.

Signature_____ Date_____

PLEASE TURN OVER

Do you…

...work at a computer for long periods?	☐Y	☐N
…have more than one pair of glasses?	☐Y	☐N
…always like to wear your glasses?	☐Y	☐N
…spend a lot of time outdoors?	☐Y	☐N
…like to change your look with different styles of eyewear?	☐Y	☐N
…want thinner, lighter lenses?	☐Y	☐N
…have prescription sunglasses?	☐Y	☐N
…have problems with glare or reflections, particularly when driving at night?	☐Y	☐N
…have difficulty with your bifocals?	☐Y	☐N
…have any interest in contact lenses?	☐Y	☐N
…have complaints about your experience wearing glasses or contact lenses?	☐Y	☐N
…have any allergies?	☐Y	☐N

If so, what are you allergic to?

_____

Would you like information or a complimentary evaluation regarding laser vision correction and your candidacy? ☐Y ☐N

Current Medications (Rx & Over-the-Counter)

			Name of Medication
Antihistamines	Yes	No	_____
Diuretics (water pills)	Yes	No	_____
Blood pressure pills	Yes	No	_____
Oral contraceptives	Yes	No	_____
Sleeping tablets	Yes	No	_____
Eye drops	Yes	No	_____
Other_____	Yes	No	_____

Are you currently under the care of a physician? Yes No

Name of physician _____

A ROUTINE EXAMINATION DOES NOT INCLUDE A CONTACT LENS EVALUATION AND/OR FITTING AND REQUIRES ADDITIONAL FEES.