Welcome To Our Office — Martin Doll, OD

Patient Information - Please Print and fill out completely in ink.

Insurance (vision/medical)_____ ID#_____

Last Name _____ First Name _____ MI _____

Birth date _____ Age _____ If under 18, Parents Name _____

Address_____ City_____ State _____ Zip _____

Home Ph #_____ Other Ph # _____ Occupation_____

Email _____Emergency Contact _____Phone # _____

Medical History - Please indicate if ***you*** have had or currently have any condition(s) listed below:

___ Dry Eye	___ Flashes of Light	___ Glaucoma	___ Asthma
___ Red Eye	___ Floaters	___ Diabetes	___Retinal Disease
___ Itchy Eye	___ Headaches	___ Heart Condition	___ HIV/AIDS
___ Eye Injury	___ Lazy/ Turned Eye	___ Thyroid Condition	___ Other
___ Double Vision	___ Eye Surgery	___ Arthritis	

Is there a family history of: ___Diabetes ___High blood pressure ___ Glaucoma ___Retinal Disease
Reason for today's visit: ___ Routine exam ___ Contact Lenses ___ Vision Problem ___ Other _____
Any known allergies to medications: _____
List of medications (include non-prescription): _____
Do you play sports? Y/N Which ones? _____
Have you ever worn contact lenses? _____ When? _____ Brand of Contacts_____
Are you interested in LASIK eye surgery? _____

Dilation (enlargement) of the pupils allows for a more thorough assessment of the eye's internal health. It is regularly recommended as part of a complete eye examination, without which, certain diseases may not be discovered. The side effects generally last 4-6 hours and include blurred near vision and sensitivity to light. You still have the ability to operate a motor vehicle, with the use of sunglasses.

Do you wish to have your eyes dilated today? ___ Yes ___No ___Reschedule

I authorize the vision care staff to perform the necessary health care services I (or my child) may need. I herby agree that I am solely responsible for paying for all products ordered and services rendered (initial here _____).

As required by federal law, a copy of the office's Notice of Privacy Practices has been provided to me. I understand that it is my right to have a take-home copy upon request, or for recycling purposes I can utilize the laminated in-office copy provided (initial here _____).

_____ Today's Date

_____ Patient (or Guardian) Signature

_____ Print Name of Signer