~ EYES OF JUPITER ~
WELCOME TO OUR OFFICE

PERSONAL INFORMATION

Date ________________

Last Name ______________________________ First ________________________ Sex _____ M _____ F

Address ____________________________________ City ________________________ State ____________

Zip _______ Home Phone (   ) ______ - ________ Cell (   ) ______ - ________ OK to text __Y __N

Birthdate: M_____D_____Y_______ Social Security # _____________________ Age __________

Employer __________________________________ Work Phone (   ) _______ - ________Ext ______

Occupation ________________________________ Hobbies _____________________________________

E-Mail Address: ____ (To remind you of your appointments)

MEDICAL HISTORY

Most recent medical examination: ________________ Results ___________________________________

Doctors Name: _________________________________ Phone # __________________________________

Medications Used ____

____

Are you allergic to any medications? ____ No If Yes, please list ___________________________

Are you pregnant? _____ No _____ Yes _____ # of months

Any history in you or your family of the following:

You	Family		You	Family		You	Family	
_____	_____	Glaucoma	_____	_____	Blindness	_____	_____	Asthma/Bronchitis
_____	_____	Cataract	_____	_____	High Blood Pressure	_____	_____	Arthritis
_____	_____	Macular Degeneration	_____	_____	Diabetes	_____	_____	Cancer/Tumors
_____	_____	Lazy Eye	_____	_____	Heart Disease	_____	_____	Fainting/Dizziness
_____	_____	Color Blindness	_____	_____	Thyroid Condition	_____	_____	Kidney/Liver Disorder

Most recent eye examination: ____________________ Reason for Today's Exam _____________________

Doctors Name: _________________________________ Phone # __________________________________

Do You : Wear glasses? ____ Yes ____ No Sunglasses? ____ Yes ____ No

Contact Lenses? ____ Yes ____ No

Do you work on a computer? ____ Yes ____ No Experience any eyestrain? ____ Yes ____ No

Any eye surgery? ____ No If Yes, why? ____

Do you use any eye medications? ____ No If Yes, please list ________________________________

(Please complete reverse side of form)

REFERRAL INFORMATION

Were you referred to our office by _____ patient _____ doctor _____phone book _____ins./vision plan

If referred by a patient or doctor please give name

DILATION: It is our goal to provide you a complete and comprehensive eye examination. This can only be done by dilating the pupil of your eyes, which allows the doctor the best view of the inside of your eyes, including the retina. Eye drops will be given that open your pupils wider, lasting 4-5 hours. This will make you sensitive to light, requiring sunglasses. If you do not have any sunglasses, some will be provided. The dilation will NOT make you unable to drive a car, just light sensitive.

The dilated exam is sometimes performed at a follow up visit. If you refuse to have a dilated exam or do not return for a follow up visit to have it done, the doctor will not accept responsibility for any diseases or defects inside your eyes that could cause permanent loss of vision or affect your general health. This is THE MOST IMPORTANT PART OF YOUR EYE EXAM.

Please read the 3 statements below and sign ONE of them.

___ I have read the above information about a dilated eye exam and understand its importance to my eye and general health. I agree to have my eyes dilated today.

Signed ______________________________

___I have read the above and understand the importance of a dilated eye exam. I will schedule and return to have my eyes dilated within the next few weeks. If I do not return to have a dilated exam, I will NOT hold Dr. Hersch responsible for any medical conditions of the inside of my eyes.

Signed __________________________________

___ I refuse to have my eyes dilated today or at a follow up appointment to this exam. I will NOT hold Dr. Hersch responsible for any conditions of the inside of my eyes that he was not able to see.

Signed _______________________________

~ Payment for the doctor is required at time of service ~

We accept the following forms of payment: Cash, Check, Discover, Mastercard and Visa. If you are paying by check, we require a valid driver's license. Returned checks will be assessed a $30.00 service charge.

Insurance Billing Patient Signature: (your signature is required below which will allow us to bill your insurance company) I request that payment of authorized insurance benefits, either to me or on my behalf, be made to Dr. Joel Hersch, for any services furnished by the doctor. I authorize any holder of medical information about me to release to Dr. Joel Hersch and any information needed to determine these benefits or the benefits payable for the related services. I also understand that if my insurance company does not provide payment to Dr. Hersch, I will be billed for and agree to pay for said service.

By signing below, I acknowledge that I have read all the information on this page.

Patient/Guardian Signature: ____ Date: __________________________