Marvin S. McMeekin,OD

3027 Wade Hampton Blvd Vision Center,Ste

We welcome you to our practice and ask that you kindly complete, or correct, all information on this sheet.

	First Name	Last Name	Health ID#:
			DOB: SSN:

Spouse/Parent:

YOUR Preferred name:

(Hm) (Wk)

EMAIL:

Address:

City:

ZIP Code:

Any history of....

Self	Family	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Macular Degeneration
☐	☐	Heart Problems
☐	☐	Retinal Detachment
☐	☐	Stroke
☐	☐	Thyroid Condition
☐	☐	Crossed/Lazy Eyes
☐	☐	Asthma/Allergies
☐	☐	Color Blindness
☐	☐	Arthritis
☐	☐	Tuberculosis
☐	☐	HIV/Hepatitis
☐	☐	Cancer
☐	☐	Neuromuscular
	☐	Blindness

Other:

____

____

____

Checkoff all that apply....

- ☐ Blurry distance vision
- ☐ Poor night vision
- ☐ Eye Strain
- ☐ Blurry near vision
- ☐ Trouble reading
- ☐ Itchy eyes
- ☐ Discharge
- ☐ Watering
- ☐ Pain in the eye
- ☐ Burning eyes
- ☐ Sandy or dry eyes
- ☐ Red eyes
- ☐ Glare/Reflections/Haloes
- ☐ Rainbows around the eyes
- ☐ Discomfort in brightness/sunlight
- ☐ Double vision
- ☐ Floaters or spots in your vision
- ☐ Flashes of light
- ☐ Dark spots in your vision
- ☐ An eye injury
- ☐ History of wearing an eye patch
- ☐ History of eye surgery
- ☐ Headaches
- ☐ Dental Abcess
- ☐ Legally blind

Are you interested in.....

- ☐ New spectacles
- ☐ A new prescription
- ☐ Light weight glasses
- ☐ Anti-Reflection coating
- ☐ Durability
- ☐ Ortho K
- ☐ Fashion
- ☐ Field of view
- ☐ Colored contact lenses
- ☐ Sunglasses, Clip ons
- ☐ Safety glasses
- ☐ Sports glasses
- ☐ Contact lenses
- ☐ Disposable contact lens
- ☐ Bifocal contact lens
- ☐ Myopia control
- ☐ Refractive Surgery
- ☐ Dry Eye therapy

How were you referred to us........

- ☐ Family Doctor
- ☐ Another Patient
- ☐ ______________________

Social history..............

- ☐ Alcohol abuse
- ☐ Drug use
- ☐ Use of tobacco

Reason for your visit:

☐ Regular check up, or....

Medications you take:
(use reverse side if needed)

Occupation/School:

Employer/Teacher:

Family Doctor:

Allergies:

Hobbies:

We thank you for completing this form

Marvin S. McMeekin, O.D.

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We welcome you to our practice and ask that you kindly complete, or correct, all information on this sheet.

Patient information

First ______ **Last** ______

SSN: ______ DOB: ______

Address: ______

(Hm) ______ (Wk) ______

(Cl) ______ Extn:

City: ______

EMAIL: ______

ZIP Code: ______

Responsible Party Information

Last Name First Name

SSN: ______ DOB: ______

Address: ______

(Hm) ______ (Wk) ______

(Cl) ______ Extn:

City: ______

EMAIL: ______

ZIP Code: ______

Primary Insurance Information

Policy Number: ______

ID Number: ______

Insured: ______

Secondary Insurance Information

Policy Number:

ID Number:

Insured:

AUTHORIZATION TO RELEASE INFORMATION: I/WE hereby authorize the practice to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration and Workers Compensation.

CONSENT FOR TREATMENT: I/We hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.

It may be necessary to use drops during the examination which may temporarily affect vision and possibily driving ability.

We thank you for completing this form

Signature: ______________________

Marvin S. McMeekin, O.D.