Dr. Jill Danker
Patrick Dollenmayer, O.D.

Welcome back to our office! Please help us to update your files so we can provide the best services possible.

Name:_____ Responsible Party:_____

Current Address: _____City: _____ Zip:_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

Please Circle Preferred Contact Number

Email: _____

Occupation: _____ Employer: _____

Dr. Jill Danker

Current Medical Insurance:_____ ID#: _____

Please Present Medical Insurance Card

Current Vision Insurance:_____ ID#: _____

Health History

Are you experiencing: Y/N

Blurred Vision? _____ Eye Discomfort? _____ Frequent Headaches? _____ Dry or Watery Eyes? _____

Current Medications:_____

_____

_____

Any hospitalizations since last visit?_____

Are you interested in discussing refractive surgery today? _____

Do you wear contact lenses? _____ Are you interested in Contact Lenses today?_____

Date of Last Eye Examination (if not in our office) _____

Thank you for entrusting the health of your eyes to us! Our commitment is to provide you with the highest standards of care. To help us serve you best, please answer the questions below so we can learn more about your vision and how you use your eyes. Our highly-trained staff will use this information to provide a vision solution that meets your needs.

Do you wear glasses or contact lenses all day?	Yes ___	No____
Do you experience difficulty with nighttime driving?	Yes____	No____
Are you in and out of sunlight throughout the day?	Yes____	No____
Do you need bifocal correction, but dislike having a bifocal line on your lenses?	Yes____	No____
Are you experience eyestrain, vision fatigue, or headaches? (Please Circle)	Yes____	No____

How many hours a day do you spend on the computer or with hobbies that require close vision? _____Hours

I have read the office policies and understand my financial obligations. I also acknowledge I have been offered a copy of the Columbus Eyecare Associates, Inc. privacy practices.

Signature of Responsible Party: _____ Date:_____