

Dr. J**ill Danker** Patrick Dollenmayer, O.D.

Name:	Re	esponsible Party:		
Current Address:		City:		Zip:
Home Phone:	Work Phone:	Ce	ell Phone:	
	Please Circle Prefe	rred Contact Number		
Email:				
Occupation:	Dr. Jill Danker	Employer:		
Current Medical Insurance:				
	Please Present Me	dical Insurance Card		
Current Vision Insurance:		ID#:		
	<u>Health</u>	History		
Are you experiencing: Y/N				
Blurred Vision? Eye [Discomfort? Freque	nt Headaches? [Ory or Watery E	yes?
Current Medications:				
Any hospitalizations since last	visit?			
Any hospitalizations since last	visit? g refractive surgery today?			
Any hospitalizations since last Are you interested in discussin Do you wear contact lenses? _	visit? g refractive surgery today? Are you intere	sted in Contact Lenses t	oday?	
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Date:

Signature of Responsible Party: