DATE_____

1701 Euclid Ave. • Bristol, VA 24201

BRISTOL (276) 466-4227

WISE (276) 679-5612

PATIENT'S NAME _____ (_____)
FIRST MIDDLE LAST PREFERRED NAME

SOCIAL SECURITY # _____ DOB_____ SEX: M_____ F_____

ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE_____ CELL PHONE_____ OK TO TEXT: Y_____N_____

EMPLOYER_____OCCUPATION_____ WORK PHONE_____

PREFERRED LANGUAGE_____ RACE_____ ETHNICITY_____

COMMUNICATION PREFERENCE PHONE ❑ EMAIL ❑ POSTAL ❑

MEDICAL INSURANCE:_____ ID#_____

SECONDARY INSURANCE:_____ ID#_____

VISION INSURANCE:_____ ID#_____

CARDHOLDERS NAME:_____

CARDHOLDER SS#:_____ DOB:_____

E-MAIL ADDRESS: _____ (OFFICE USE ONLY)

PURPOSE OF THIS APPOINTMENT: (ROUTINE, EYE IRRITATION, ETC.) _____

ARE YOU INTERESTED IN GLASSES OR CONTACTS?_____

HAVE OTHER MEMBERS OF YOUR FAMILY SEEN DR. WEBERLING & ASSOCIATES: Y_____ N_____

NAME OF SPOUSE_____ REFERRED BY_____

ARE YOU TAKING ANY MEDICATIONS (IF SO LIST: BIRTH CONTROL, VITAMINS, ETC.) _____

DO YOU USE TOBACCO PRODUCTS? ❑ NO ❑ YES IF YES, TYPE/AMOUNT/HOW LONG:_____

DO YOU DRINK ALCOHOL? ❑ NO ❑ YES IF YES, TYPE/AMOUNT/HOW LONG:_____

DO YOU USE ILLEGAL DRUGS? ❑ NO ❑ YES IF YES, TYPE/AMOUNT/HOW LONG:_____

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH: ❑ GONORRHEA ❑ HEPATITIS ❑ HIV ❑ SYPHILIS

NAME OF PHYSICIAN_____ PHONE:_____

ADDRESS:_____

DATE OF LAST COMPLETE EYE EXAM (INCLUDING GLAUCOMA TEST)_____ LAST PHYSICAL EXAM_____

PROFESSIONAL FEES ARE DUE AT THE TIME THE SERVICES ARE RENDERED. A $10 BILLING CHARGE WILL BE APPLIED WITHOUT EXCEPTION TO ANY OUTSTANDING BALANCE AND WILL ACCRUE MONTHLY. $25 RETURNED CHECK FEE. PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTION OR LEGAL ACTIONS.

THIS INFORMATION IS CONFIDENTIAL AND WAS GIVEN BY (SIGNATURE)_____