Welcome to the Office of Peter E. Sforza, Jr., OD

Patient's Name_____

Address_____City_____State____Zip_____

Cell Phone (____)_____ Home Phone (if applicable) (____)_____

E-Mail Address_____

Patient's Date of Birth ____/____/_____ Social Security Number _____

Occupation_____ Employer_____

Special Visual Demands (Work or Hobbies):_____

Please circle who referred you to our office: ***Insurance Listing*** ***Yellow Pages*** ***Web Search*** ***Friend*** ***Family Member*** *Name*_____

Please circle if you have ever had any of the following: ***Cataracts*** ***Glaucoma*** ***Diabetes*** ***Lazy Eye*** ***Macular Degeneration*** ***High Blood Pressure*** ***Allergies***

Do You Smoke? ***Yes / No***

List any other Medical Problems:_____

Family Physician_____ Pharmacy_____

List of medications:_____

Have you ever had any eye injury or surgery to your eyes? ***Yes / No*** Describe_____

Previous Eye Doctor_____

Have any blood line relatives had glaucoma, or other loss of sight? ***Yes / No***

Are you allergic to any medications? ***Yes / No*** List: _____

Do your presently wear glasses? ***Yes / No*** When do you wear them? _____(ex: just for reading)

How old are your present glasses? _____ years

Do you presently use contact lenses? ***Yes / No*** If no, have you ever used contacts? ***Yes / No***

PAYMENT POLICY- Payment for professional services is required at the time the service is rendered. If ophthalmic materials are ordered, a deposit of at least half is required before materials will be ordered from the lab and the balance is to be paid in full at the time of dispensing. In some cases, payment in full may be required. If insurance will be used to pay for services, you will be responsible for any balance not paid by the insurance company.
I hereby authorize Peter E. Sforza, Jr., OD to release any vision or medical information that may be necessary for medical care or in the processing of insurance claims. I, also, hereby authorize payment of insurance benefits to Peter E. Sforza, Jr., OD for services.

SIGNATURE_____ Date_____
(Patient, Parent, or Guardian)