Dr. Stephen S. Jennings, Optometrist

"GET ACQUAINTED OR REACQUAINTED FORM" Please Print, Fill Out Form & Bring with You to Appt.

Patient's Name _____ Date of Birth ____/____/____ SS # _____
Address _____ City_____ Zip_____
Home Phone _____ Work Phone _____ Is it OK to call at work? Y N
Email Address: _____
Occupation _____ Employer _____ Vision coverage? Y N

Medical Insurance Co. _____ Policy # _____

Group # _____ Medicare # _____ Medicaid # _____
Have you met your deductible this year? Y N Not Sure

Other persons(s) responsible for payment _____ Relation _____

Address (if different from above)_____

Phone (if different from above) Home _____ Work _____

Verification and Assignment of Insurance Benefits

I authorize Dr. Jennings to contact my insurance company, employer, or other third party payor to verify my insurance or other applicable coverage in consideration for services rendered and convey Dr. Jennings any and all my rights and interests which I may have to any and all insurance benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account for services rendered is paid in full.

I understand I am ultimately responsible for all payment or any amount or deductible not covered by my insurance when services are completed. I also understand that glass lenses are the least impact resistant lens material and while plastic is better than glass the polycarbonate material is the most impact resistant material available to me for my eyes protection.

Signature _____ Date _____

How did you hear about our office? Phone Book 'Friend/Family · Insurance · Doctor's office (Please Circle)

Who referred you?_____ Are you: Single Divorced Widowed? (Please Circle)

If married, Spouse's Name _____ D.O.B.____/___/___
Employer _____ Work # _____ Is it OK to call at work? Y N

SS # _____ Any vision coverage? Y N Ins. Company_____
Children's Name(s) Optional 1)_____ age_____ 2)_____ age_____,
3)_____ age_____, 4)_____ age_____,
*5)*_____ age_____
Patient's former optometrist or ophthalmologist_____
Last exam ____/_____/____ Reason for appointment today_____
Do you have glasses? Y N Use of Glasses: Distance / Near / Both / Bifocal
Do you have contact lenses? Y N Type & Brand of contacts _____
Do you use sunwear for your eyes? Y N Safetywear? Y N

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"GET ACQUAINTED OR REACQUAINTED FORM" Please Print, Fill Out Sheet & Bring with You to Appointment – Thank You!

Do you use a computer? Y N If so, how many hours per day?_____

Hobbies or sports_____

Are there any other work or recreational activities that you think might be giving you problems with your eyes or headaches? Y N
If so, what are they?_____

MEDICATIONS and ALLERGY REQUEST or PLEASE BRING YOUR LIST

Please list any medicines you take whether prescription or non-prescription, since they may effect your eyes. We also need to know of any allergies you may have.

Prescription Medications:

Non-Prescription Medications:

Allergies:

Vitamins and Supplements:

Contact Lens Wearers:
Please bring any contact information you have along with your contact lens case and glasses.

Thank you for Printing this out at Home, filling it out and bringing it with you.

Dr. Stephen S. Jennings, O.D. and Staff 2 Locations to serve you:
Lakeside Medical Center, 2301 Hilliard Rd., Henrico, VA 23228- / 804-262-5142/ Fax 804-2626257
Hilltop Medical Building, 9291 Laurel Grove Rd., Mechanicsville, VA 23116
Phone: 804-730-4171 / Fax: 804-730-0438 - Hours Mon – Fri Closed Sat & Sun.
Please visit us on the Web: http://www.drstephenjenningsod.com