George J. Kaknis, OD
1073 Main Street
Suite 106
Fishkill, New York 12524

Mr.
Mrs. **Patient Name**:_____
Ms

Address_____City _____State _____Zip_____
Home Phone_____ Date of Birth_____/_____/_____
Work Phone_____ Cell Phone_____
Date of Last Exam_____ Primary Care Physician _____
Vision Insurance_____Medical Insurance_____
Supplement (if applicable)_____Last 4 digits of patient social security#_____
Is this coverage through: self, spouse or parent? _____
Subscriber's name_____ Employer_____
Last 4 digits of social security #_____Date of Birth_____/_____/_____
Do you work with a computer? _____If so, hours per day_____
Do you wear contact lenses?___-If yes, name of brand:_____Base curve:_____
Prescription for contact lenses: **Right eye**:_____**Left eye**:_____
If you do not wear contact lenses are you interested in them? **Yes / No**
Are you interested in Laser Vision Correction? **Yes / No**
Who referred you to our office:_____

General Health Section: (Check all that apply)

_____Diabetes
_____High Blood Pressure
_____Smoker
_____Heart Disease
_____Asthma
_____Emphysema
_____Elevated Cholesterol
_____COPD
_____Seizures
____Kidney Disease
_____Liver Disease
_____Eczema
_____Thyroid Disease
_____Rosacea
_____Head Injuries
_____Cancer, Type:_____
_____Arthritis, Type:_____
_____Anxiety
_____Depression
_____Schizophrenia
_____Ulcerative colitis
Surgery:_____
_____

Eye History

_____Eye Injuries
_____Eye Surgery
_____Glaucoma
_____Retinal Detachments
_____Cataracts
_____Macular Degeneration
_____Uveitis/iritis

Family Ocular History

_____Glaucoma
_____Retinal Detachments
_____Cataracts
_____Macular Degeneration
_____Other:_____
_____

List **all** medication that you are currently taking_____
_____

List **all** medication that you are allergic to_____

Read and sign next page→

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. For participating plans, I authorize and request my insurance company to pay directly to **George Kaknis, O.D.** insurance benefits allowed. I understand that my eyecare insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Payment for examination is due at time of service and a 50% deposit for eye glasses/contacts is required when ordering them. Full payment at dispensing. Also, due to the custom nature of glasses, we do not provide exchanges/refunds once they are ordered. Thank you.

Patient's Signature:_____ **Date**:_____
(IF minor, parent or guardian must sign)