George W. Kledaras, O.D., P.A.
Penny Hill Eye Center

Special Interests in Glaucoma, Contact Lenses, and Children's Vision

Welcome to Our Office

Patient's Name: _____

Age: _____ Date of Birth: _____

Spouse's / Parent's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ email: _____

Employer / School: _____ Social Security #: _____-____-_____

Has anyone in your household ever been a patient of ours? Yes No

If so, who? _____

Have you ever worn glasses? Yes No Contact lenses? Yes No

Do you presently wear glasses? Yes No Contact lenses? Yes No

Are you under a physician's care or taking prescription medication or drugs for any reason?

Yes No

Who is your primary care doctor? _____

Have you ever had any type of eye surgery or eye disease? Yes No

Who recommended us or referred you? _____

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Insurance Authorization & Privacy Policy

I authorize any holder of medical or other information about me to release to my insurance carrier(s) any information needed for this or any future claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I acknowledge that I received a copy of George W. Kledaras O.D., P.A.'s Notice of Privacy Practices (Effective date of notice: 9/30/13).

Signature:_____ Date:_____

Please bring this completed form with you to your appointment

We appreciate the opportunity to serve you.