MASON
EYE CLINIC

WELCOME TO OUR OFFICE

DR. JOHN H. MASON
DR. AUSTIN MASON
BOARD CERTIFIED
OPTOMETRIC PHYSICIANS

Who may we thank for referring you? _____

DATE:

Patient's Last Name	First Name	MI	Gender	Birth Date	Age

Address	Apt #	City	State	Zip

Home Phone	Work Phone	SS#	Insurance

Employer Occupation:	Emergency Contact Phone #	Insurance ID#

Primary Dr.: Last Exam:	Email:	Relationship to Insured ☐ SELF ☐ SPOUSE ☐ DEPENDENT

What is the reason for your visit today?

- ☐ Routine Eye Exam
- ☐ Contact Lens Exam
- ☐ Medical Office Visit
- ☐ Diabetic Eye Exam
- ☐ Dry Eye
- ☐ Myopia Control
- ☐ Other _____

SELF	FAMILY	Personal / family medical history:
☐	_____	High blood pressure
☐	_____	High Cholesterol
☐	_____	Heart Disease
☐	_____	Diabetes
☐	_____	Stroke
☐	_____	Cancer
☐	_____	Kidney
☐	_____	Thyroid

SELF	FAMILY	
☐	_____	Arthritis
☐	_____	Retina Problems
☐	_____	Glaucoma
☐	_____	Cataracts
☐	_____	Eye Surgeries

explain: _____

☐ smoker ☐ non-smoker

Last Eye Exam: _____

Where? _____

Allergies:

Pregnant? ☐ Yes ☐ No

Current Medications with dosage:

Are you interested in Contact lenses?

Do your eyes feel dry?

Do you currently wear prescription sunglasses?

Please see attached flyer about Optomap® photo and iWellness OCT scan:

Optomap®

☐ YES, I would like the OptoMap photo

☐ NO, I would not like the OptoMap photo

iWellness OCT scan

☐ YES, I would like the iWellness OCT scan

☐ NO, I would not like the iWellness OCT scan

Authorization of Medical Treatment

I request the payment of authorized medical benefits to be made to Dr. Mason on my behalf for any services provided to me by that physician. I authorize the holder of medical information about me to release the HCFA and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. I understand that I am financially responsible for all changes whether or not paid by my insurance. I authorize the use of this signature on all my insurance submissions. The patient and/or responsible party agree to pay all collections, attorney and court fees that may be incurred for delinquent accounts.

_____ _____

Signature Date