Welcome To Our Office!
Dr. Jeffrey L. Morer, Optometrist
561/969-9995

PATIENT INFORMATION

Today's date_____ New patient? ❒Yes ❒No (please update any changes)

Last name _____First name_____

Street address_____

City_____ State_____ Zip _____

Telephone w/area code (cell) _____(work or home)_____

Date of birth_____ If under 18 name of parent _____

Occupation_____ Email address_____

Hours per day using computer_____ Hobbies/interests_____

How did you learn about our office? _____

MEDICAL INFORMATION

When was your last eye exam?_____ Dr's name_____

When was your last physical exam? _____ Dr's name_____

➔**Reason for visit**: ❒ Blurred vision: far/near or both?_____ ❒ Eye discomfort or pain; ❒ Contact lens fitting;

❒ Other (describe problem)_____

➔**Contact lens patients**: current brand and prescription _____

_____

IMPORTANT NOTE REGARDING DILATED EYE EXAMS

In accordance with Florida Board statutes and standards of care for medical practice, *new* patients to this office who require a comprehensive eye examination can expect to have their eyes dilated. Dilation is required in order to conduct a thorough eye health evaluation. After dilation, your vision may be blurred and you may be light sensitive for 4-6 hours. Please speak to the doctor if you have any questions or wish to re-schedule this procedure.

FOR MEDICARE COVERED SERVICES ONLY

Medicare number_____ Secondary insurance_____

CONSENT (SIGNATURE REQUIRED)

I hereby assign all benefits to Jeffrey L. Morer, O.D. for professional services rendered. This assignment includes benefits payable by Medicare, Medicaid and Medigap programs, if applicable. I authorize the release of all information from all sources necessary to secure payment for services rendered. I agree to be responsible for all costs for professional services and understand professional examination fees are non-refundable.

Signature _____ Date_____

Thank you and welcome!