

DATE _____

Dominick A. Marino O.D., P.A.
4530 PGA Blvd. Suite 105
PBG, FL 33418
561-799-2461

Patient's Name (Mr., Mrs., Miss, Dr.) _____

Age _____ DOB _____ If student, grade _____

Address _____ City _____ Zip _____

Home Phone _____ Business Phone _____ cell _____

Employer _____ Occupation _____

HOW DID YOU FIND US? Phonebook _____ Internet _____ Newspaper _____ Insurance _____ Walked By _____
Former patient _____ Referred by a patient _____ Name of referring patient _____

Medical Information: Check if you have or have had:

Allergies _____ High Blood pressure _____ Epilepsy _____
Sinusitis _____ Arthritis _____ Drug Sensitivity _____ Eye injury _____
Migraines _____ Hypoglycemia _____ Eye disease _____ Glaucoma _____
Diabetes _____ Blood disease _____ Eye surgery _____ Currently pregnant _____
HIV/AIDS _____ Other _____

Name of medications used: _____

Check if your eyes are bothering you in the following ways:

Blur _____ Water _____ Tired _____ Floaters _____
Headaches _____ Burn _____ Ache _____ Redness _____
Double Vision _____ Itch _____ Dry _____ Glare _____
Night Blindness _____ Other _____

Do you wear glasses now? _____ Contact lenses? _____ Last eye exam date _____

Are you interested in contact lenses? _____

It is customary to pay for professional services at the time they are rendered. Fees are payable by Cash, Check, Visa, Mastercard, Discover

Signature _____