



OCULAR PROSTHETICS, LLC

New Patient Information

Paper form only. Please print and complete it, then bring it to your visit or fax it to (864) 305-4369. Do not email this form or send it by text.

Patient

Full name: _____

Date of birth: _____

Address: _____

City / State / ZIP: _____

Phone: _____

OK to leave a voicemail or text? (Yes / No): _____

Emergency contact

Name and relationship: _____

Phone: _____

Parent or guardian (if the patient is under 18)

Name: _____

Phone: _____

Insurance

Please bring your insurance card(s) and a photo ID. We will copy them at your visit.

Primary insurance: _____

Secondary insurance: _____

Veteran? VA referral or authorization number (if any):

Workers' compensation claim (if any): _____



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Referring doctor

Doctor or practice: _____

Phone / fax: _____

About your eye

Which eye? (Right / Left): _____

Cause of eye loss or condition (if known): _____

Date of surgery (if any): _____

Type of surgery (enucleation, evisceration, other, unsure):

Do you have a current prosthesis or scleral shell? Who made it, and when?:

What would you like help with today?: _____

Health history

Allergies (especially to medications, latex or acrylic):

Current medications and eye drops: _____

Other health conditions we should know about: _____

Signature

I confirm this information is correct. I have received the financial policy and understand payment is due at time of service.

Signature: _____

Date: _____

[CONFIRM: Tim to review the fields; add a HIPAA privacy notice acknowledgment and financial-policy signature if that isn't done elsewhere]