Dr. Howard Misheloff, 0.D.

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Contacts

LAST NAME	FIRST NAME	TODAY'S DATE
HOME ADDRESS	CITY	STATE ZIP

PHONE NUMBERS			MALE M / F FEMALE	YOUR BIRTHDAY DATE		
HOME: ( )	WORK: ( )	CELL: ( )		MONTH	DAY	YEAR
SOCIAL SECURTIY	DRIVERS LICENSE					

RX 1	QUANTITY	BRAND	B.C.	PRISM	POWER	CYL / ADD	AX	DIAM	TYPE
OD									
OS									
RX 2 OD									
OS									
RX 3 OD									
OS									

- ○ NEEDS TRAINING
- ○ PT. NEEDS TORIC
- ○ PT. NEEDS B.F.
- ○ O.K. TO ORDER BOXES
- ○ PT. NEEDS CL BY DATE ___/___/___

REFIT #1 DATE ______
OD: ______
OS: ______

REFIT #2 DATE ______
OD: ______
OS: ______

REFIT #3 DATE ______
OD: ______
OS: ______

REFIT #4 DATE ______
OD: ______
OS: ______

REFIT #5 DATE ______
OD: ______
OS: ______

REFIT #6 DATE ______
OD: ______
OS: ______

PATIENT NAME

	BOXES	$ CHARGE
EXAM/REFRACTION		$
RECHECK/EXAM INSURANCE CO-PAY		$
CL TRAINING		$
EYE DISEASE TREATMENT EXAM		$
CL EXAM FIT		$
B.F. SPH		$
EW./DW. SPH / TORIC		$
DISPOSABLE / FREQ REPL SPH		$
COLOR SPH / TORIC		$
CUSTOM / QUAR / TORIC		$
FR-RPL-TORIC		$
GAS PERMS/HARD		$

DATE
TOTAL FEE $
COUPON OR DISCOUNT $
AMOUNT PAID $
PATIENT BALANCE $
INSURANCE BALANCE $

METHOD OF PAYMENT

- ○ CASH
- ○ CHECK
- ○ CREDIT CARD TYPE ______
- ○ INSURANCE NAME ______

DISPENSED DATE

1st Pair	2nd Pair	3rd Pair
DATE:	DATE:	DATE:

INSURANCE AUTHORIZATION # ______

INSURANCE NAME ______

PATIENT SIGNATURE ① ______ / ② ______ / ③ ______

DISPENSER'S NAME ① ______ / ② ______ / ③ ______

DIAGNOSIS: PATHOLOGY:

	B.C.	O.C.	VA'S WITH OLD RX
PRIOR	OD		20/
RX	OS		20/
	ADD		20/
AGE:	OD		20/
	OS		20/
TYPE:	ADD		20/

UNAIDED VA'S		VA	OD 20/	OS 20/	OU 20/	NEAR 20/
KERATOMETRY	OD		X	AXIS	MIRES	
	OS		X	AXIS	MIRES	

RETINOSCOPY OD

OS P.D. /

SUBJECTIVE OD 20/

DISTANCE OS 20/

PHOREAS________ DISTANCE________ DUCTIONS________

HORIZ VERT.

NEAR	ADD	AT	DIST	20/
COMPUTER	ADD	AT	DIST	20/

NEAR PHORIAS____________ DUCTIONS____________

CHIEF VISUAL COMPLAINT:

COVER TEST:

VERSIONS:

N.P.C.:

EXAMENING DR.'S SIGNATURE________________________

DILATION YES NO MEDS USED:

PT. REFERRED TO:

MEDICAL HISTORY

ANY HEALTH PROBLEMS? ____________________

ANY MEDICATIONS? ____________________

ANY HISTORY OF EYE DISEASE? ____________________

FAMILY HISTORY OF GLAUCOMA? ____________________

OR DIABETES? ____________________

OR MACULAR DEGENERATION?

EXTERNAL

LIDS CONJ. SCLERA

PUPIL REFLEXES

CORNEA

LENS

MEDIA

____

EXAMENING DR.'S SIGNATURE

DISC RATIO

VESSELS AV RATIO

BACKGROUND

FOVEAL RELFEX

I.O.P. OD OS TIME : A.M. OR P.M.

MM/ HG OD OS TIME : A.M. OR P.M.

CONFRONTATION TEST

SLIT LAMP FINDINGS

COLOR VISION:

STEREO TEST PLAN:

DIAGNOSIS

P.T.'S VOCATIONAL NEEDS

① **RECHECK INFORMATION O.K. TO ORDER BOXES**

DATE: ____________________

DR.'S NAME ____________________

PATIENT COMPLAINT ____________________

WEARING TIME ____________________

VA'S WITH CONTACTS: OD.__________ OS.__________

OVER REFRACTION: OD.__________ OS.__________

SLIT-LAMP: ____________________

② **RECHECK INFORMATION O.K. TO ORDER BOXES**

DATE: ____________________

DR.'S NAME ____________________

PATIENT COMPLAINT ____________________

WEARING TIME ____________________

VA'S WITH CONTACTS: OD.__________ OS.__________

OVER REFRACTION: OD.__________ OS.__________

SLIT-LAMP: ____________________

③ **RECHECK INFORMATION O.K. TO ORDER BOXES**

DATE: ____________________

DR.'S NAME ____________________

PATIENT COMPLAINT ____________________

WEARING TIME ____________________

VA'S WITH CONTACTS: OD.__________ OS.__________

OVER REFRACTION: OD.__________ OS.__________

SLIT-LAMP: ____________________

④ **RECHECK INFORMATION O.K. TO ORDER BOXES**

DATE: ____________________

DR.'S NAME ____________________

PATIENT COMPLAINT ____________________

WEARING TIME ____________________

VA'S WITH CONTACTS: OD.__________ OS.__________

OVER REFRACTION: OD.__________ OS.__________

SLIT-LAMP: ____________________