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DATE: _____

NAME: _____ AGE: _____ D.O.B.: ____/____/____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

SEX: M / F EMAIL ADDRESS: _____ REFERRED BY: _____

PHONE NUMBERS: (HOME) _____ (WORK) _____ MARITAL STATUS: M S D W

OCCUPATION: _____ COMPANY NAME: _____

WORK ADDRESS: _____

EMERGENCY CONTACT: _____ Telephone #: _____

INSURANCE CARRIER: _____ SS #: _____ GROUP #: _____

INSURANCE ID (if different from SS#): _____

PRIMARY CARDHOLDER'S NAME: _____ DATE OF BIRTH: _____

MEDICAL HISTORY: PLEASE CHECK IF YOU HAVE THE FOLLOWING:

___ HIGH BLOOD PRESSURE ___ DIABETES ___ THYROID DISEASE ___ EYE DISEASE

HAVE YOU EVER HAD EYE SURGERY OF ANY KIND? ___ YES ___ NO

IF YES, TYPE OF SURGERY: _____

DO YOU HAVE ANY DRUG ALLERGIES? ___ YES ___ NO IF YES, PLEASE LIST: _____

DO YOU TAKE ANY MEDICATION DAILY? PLEASE LIST (INCLUDE EYE MEDICATIONS): _____

DO YOU HAVE A FAMILY HISTORY OF ANY EYE DISEASE SUCH AS GLAUCOMA? PLEASE LIST: _____

DO YOU WEAR GLASSES?: ___ YES ___ NO CONTACTS?: ___ YES ___ NO

ARE CONTACTS LENSES SOFT? ___ HARD OR GAS PERMEABLE? ___

DO YOU SLEEP IN YOUR CONTACTS? ___ YES ___ NO

HOW LONG HAVE YOUR CONTACTS BEEN OUT OF YOUR EYES? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS SO THAT WE MAY HONOR YOUR PRIVACY:

May we leave a message on your answering machine at home? ___ YES ___ NO

May we leave a message at your place of employment? ___ YES ___ NO

May we discuss your medical condition with a family member? ___ YES* ___ NO

*If yes, name of family member: _____ Relationship: _____

Signature: _____ Date: _____