5688-A West Broad Street
Galloway, OH 43119
Phone: 614-853-2020 Fax: 614-853-0154
Jennifer A. Mattson, O.D., Richard J. Vesler, O.D., Rheanna Moore, O.D.

Name: ____ Date: _____/_____/_______
Age: _________Date of Birth:____/____/______Gender: M / F Salutation: Mr. Miss Ms. Mrs. Dr.
Address: ________________________________City: _________________State: ____ Zip Code: ________
Home Phone: (_____)_____-______Cell Phone:(____)______-_________Work Phone:( )____-__________
Social security number: ____________________ Email address: _________________________________
Guardian (if patient is under 18): ______________________________Salutation: Mr. Miss Ms. Mrs. Dr.

Vision insurance carrier: VSP EyeMed Medicaid/Caresource/Molina Other: ________________
Medical insurance carrier: Anthem Aetna Cigna Medical Mutual Medicare
Tricare Meritain Humana United HealthCare Other: ____________
Primary insured name: ________________________________ DOB: __________________________
Secondary insurance name:_____________________ Ins ID#________________ DOB: _____________
**Please have your insurance cards ready for our staff to copy, thank you. Co-pays are due at the time of service.

Reason for Examination (circle all that apply): blurred vision at distance / near / computer

eyes watery/itchy eyes dry headaches eyestrain eye pain redness flashes/floaters

annual exam for diabetes annual exam for hypertension need new contact lenses / glasses

referred by another doctor vision therapy assessment reading problems double vision

Ocular History:
Do you wear… glasses contact lenses both Are you interested in contact lenses? Y / N
Age of current glasses __________________ Do you use a computer? Y / N #hours/day: ________
Current contact lens wearers only:
Replacement schedule: __________________Average wearing time daily: __________________
Solution used: __________________________________Do you sleep in your lenses? Y / N
If you could change something about your lenses it would be: ______________________________________

***Contact lens services are not covered under a regular eye exam.** In order to obtain a prescription for contact lenses, an additional evaluation (contact lens fitting) must be done. The price for this service varies based on your prescription and the complexity of the fit. Your fitting fee will cover any necessary follow up visits and any diagnostic lenses used to determine your contact lens prescription. Our doctors are committed to your success in contact lenses. If you have questions regarding this fee, please talk to a staff member.

Please list your current medications (including vitamins/OTC drugs): ____________________________

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Please list any drug allergies: ____