



EYE HEALTH
PROFESSIONALS, P.C.

John W. Redmond, M.D.

REGISTRATION FORM

Please Print

Name: _____ Date: _____

Address: _____ City: _____ Zip: _____

Telephone: _____ home _____ cell _____ work

Please tell us where to call you: home cell work Where may we leave a message? home cell work e-mail address: _____

Date of birth: _____ Gender: M F

Family Physician: _____

Employer: _____

Occupation: _____

Business address: _____ City: _____ Zip: _____

How did you hear about us? _____

Is there someone we can thank for sending you? _____

Our prescriptions are done electronically. Please tell us the name of your primary

Pharmacy _____ and its location



EYE HEALTH PROFESSIONALS, P.C.

JOHN W. REDMOND, M.D.

CATARACT SURGERY
GLAUCOMA TREATMENT
DRY EYE THERAPY

COSMETIC EYELID SURGERY
BOTOX INJECTIONS
LASER SKIN REJUVENATION

REFRACTION CHARGE

I understand that during any examination I may have a refraction. This charge is a necessary part of your complete eye exam and is for the optical determination of the best possible vision. It is also needed to determine if any medical or surgical treatment is indicated.

The refraction charge of \$40.00 is not covered by Medicare and is not usually covered by any other insurance plan as they consider this to be "routine".

I may decline this service. If a refraction is performed, payment is expected at the time of service. I understand that I am ultimately responsible for this charge if it is not covered by my insurance carrier.

Date:

Name:

I elect to have a refraction

Patient Signature

I decline the refraction

Patient Signature

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