Johnston Ocular Prosthetics, Inc.
Lisa C. Johnston, BCO BADO
Specialist in Making Artificial Eyes Since 1954
P.O. Box 1201
Benson, NC 27504-2201
919-207-2515 Bus.
919-894-1335 Fax
www.JOPInc.com

Welcome to the family!
You no doubt have many questions, of which we will be more than happy to answer for you. To insure the Accuracy and Quality of our service and support to you, we also will need to ask several questions. Please provide, in as much detail as possible, the information being requested below. If you have any questions on the form, please do not hesitate to ask one of our associates for assistance. PLEASE PRINT-THANK YOU

Patient's information

Last Name____**First Name**_______________________ **Middle Initial**_______________

Address____**City**____________________**State**____________**Zip**________________

Date of Birth_____________________________________**Social Security #**____

Phone # (_______) _________________—_______________Work # (________)________________—__________________________

Artificial Eye (please circle one) Left—Right —Both HIV YES or NO Male Female

Referring Doctor- Ophthalmologist information

Last Name____**First Name**__________________**Middle Initial**_____________________

Address____**County**____

City____**State**__________________ **Zip code**____________________________

Date Last Seen___________________________________ **Phone # (_____)___________—___________________________________**

Insurance Information (We will need to copy your insurance cards)

Primary Insurance_________________________________

Prosthetic History

When did you originally lose your eye(s) give date ?____
Original cause for loss of eye(s) ?____
Most recent surgery date?____
Do you have an implant (Coral or Medpore Bio-eye)? ____
Who was your previous Ocularist, if different than Johnston Ocular Prosthetics, Inc. ?______________________________
Current age of Prosthesis?____
Do you wear contacts or glasses?____

Note: Our office Management is available to assist you, as a complimentary service, for filing your insurance forms.
Note: Medicare forms will always be filed by our office management.
IMPORTANT– We are transitioning from credit card payments to Checks and Cash Only.
I hereby assign ALL insurance payments to which I an entitled to be paid directly to Johnston Ocular Prosthetics, Inc. unless otherwise directed. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I herby Authorize said assignee to release all information necessary to secure the payment of said benefits. My signature at the bottom of this form, authorizes Johnston Ocular Prosthetics, Inc. to act in my behalf.
We are working with our patients to create a digital database of electronic photos. With your permission we would like to add a digital photo file of your prosthesis. If you are not in agreement with this process, please inform one of our staff members. The file will be kept solely for Johnston Ocular Prosthetics, Inc. business use.

Signature____ **Date**____

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