



**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

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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 # \_\_\_\_\_ Email : \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_ — \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ — \_\_\_\_\_

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 Front and Back)**

Primary Insurance and / or Secondary 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 and NC Medicaid forms will always be filed by our office management.

**IMPORTANT- WE ARE NO LONGER ACCEPTING CREDIT CARD PAYMENTS! We are sorry for the inconvenience.**

I hereby assign ALL insurance payments to which I am 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 hereby 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.

If you have North Carolina Medicaid and assigned to Carolina Assess Clinic, Please get a referral from your PCP.

Signature \_\_\_\_\_ Date \_\_\_\_\_

[www.JOPInc.com](http://www.JOPInc.com)

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