

Welcome to Our Office

This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.

Name: _____ Marital Status: _____ Date of Birth: ___/___/___
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Patient SS#: _____ Email Address: _____
Employer: _____ Occupation: _____ Phone: () _____
Spouse/Guardian's Employer: _____ Position: _____
Phone: Hm () _____ Wk () _____ Spouse/Guardian's SS#: _____
If student, grade level _____ School _____
Account Responsible: Name _____ Phone: Hm () _____ Wk () _____
Emergency Contact: _____ Phone: Hm() _____ Wk() _____ Cell() _____
Who may we thank for referring you? _____

INSURANCE INFORMATION

(Please present your insurance card so we can copy it for our files)

Vision Insurance Name: _____ Subscriber ID # _____
Subscriber Name: _____ Address: _____
Date of Birth: ___/___/___ Sex: _____ Relation to Patient: _____
Medical Insurance Name: _____ ID/Plan # _____
Family Physician Name: _____ Phone # _____
Employer Address: _____ Phone: () _____
Reason for today's visit: Contact Lens Exam ___ Eyeglass Exam ___ Office Visit ___ Other _____
Are you interested in contact lenses? Yes ___ No ___
Are you interested in glasses? Yes ___ No ___
Are you interested in refractive surgery? Yes ___ No ___
Method of Payment Today: Cash ___ Check ___ Credit Card ___ Insurance ___

I understand that if my eligibility cannot be verified or if I do not obtain the proper referral form when required, I will be financially responsible for payment of all charges incurred for services received from this doctor's office. Payment is expected at the time of service. In the event this account becomes delinquent, the undersigned agrees to pay any necessary collection fees/attorney fees of no less than 50% added to the unpaid balance and court costs. Any unpaid balance may be subject to a 1½% monthly service charge.

By signing this form, I consent to treatment for myself and/or on behalf of the minor for which this information pertains. I give permission for the doctor/s to examine and initiate treatment as deemed appropriate. I further attest that I am the parent Or legal guardian of the minor and have authority to authorize care and treatment.

Signature Patient/Parent/Guardian Relationship _____ Date ___/___/___

Tell us about your lifestyle...

What hobbies or activities do you enjoy? _____

What special vision needs do you have? _____

Polycarbonate lenses are the most impact resistant lenses available and are the safest for children, sports, and any other activity where your eyes may become injured. _____

Your initials

Please hand this page to the receptionist when finished so that we can shorten your waiting time before your examination.

Thank you.