



Welcome to Our Office

For faster service, please complete this form prior to arrival.

Appointment Date _____

Patient Name _____

If a Child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Email Address _____

Birth Date _____ M or F _____ SSN _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's Date of Birth _____

Spouse's SSN _____ Spouse's Employer _____

Patient's Insurance Carrier _____

Spouse's Insurance Carrier _____

Please give your insurance cards to the receptionist

How did you hear about our office? _____

Are you planning on getting new glasses today? Yes No

How old are your current glasses? _____

I authorize the release of any medical information necessary to provide the most beneficial and complete vision examination. I understand that I am financially responsible for all charges whether or not paid by my insurance. All insurance co-payments, co-insurance and deductibles are due at the time services are rendered. I further acknowledge that any unpaid insurance claim older than 60 days is my financial responsibility.

Signature _____ Date _____