

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.

Your Name Miss _____
Mrs. _____
Ms. _____
Mr. Last First Middle Nickname or Preferred
Dr. _____
Rev. _____

Your Address _____
Street or P.O. Box City State Zip

Your Date of Birth ____/____/____ SS# ____-____-____ e-mail _____

Phone numbers cell (____) ____-____ home (____) ____-____ work (____) ____-____

Your Employer _____ Your Family Doctor _____

Your Preferred Pharmacy _____ Where is it? _____

If married, name of spouse _____ Spouse employed by _____

If under 18, parent or guardian's name _____

Relation _____ Phone ____-____ Employer _____

If student, grade level _____ School _____ Teacher _____

Why did you come to us? _____ Who may we thank for referring you? _____

Your occupation and lifestyle play the most important roles in determining your visual requirements.

How do you use your eyes at work? _____

What hobbies or activities do you enjoy? _____

What special vision needs or problems do you have? (glare, night vision, etc.) _____

How will you be paying today? Full payment by cash, check, or credit card Vision Care insurance with deductible

“I request that payment of benefits be made to me or the doctor for any services provided. I also authorize any holder of medical information about me to release to the carrier and its agents any information needed to determine these benefits or the benefits payable for related services.”

“I understand that any services not covered by insurance and co-pays are due at time of service.”

“I also acknowledge that I have had an opportunity to receive a copy of the Privacy Practices and Policies of this practice.”

signature date

Thank You.