Welcome To Our Office

Patient's Information

Name _____ Date of Birth _____
First MI Last

I would like to be called _____ SS # _____

How did you hear about us? _____

Family's Information

Addresses

Home Street _____

Home CSZ _____

Alternate Street _____

Alternate CSZ _____

Phones

Whose	Where	Number	Ext

EMail Addresses

Whose	Where	Email Address	Whose	Where	Email Address

Insurance Information

Vision Insurance

Employee _____

Employee SS# _____

Employee Member ID _____

Employer _____

Insurance Company _____

Insurance Plan _____

Patient's Relationship to Employee _____

Patient's Member ID _____

Health Insurance

Employee _____

Employee SS# _____

Employee Member ID _____

Employer _____

Insurance Company _____

Insurance Plan _____

Patient's Relationship to Employee _____

Patient's Member ID _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time of services.

Signature _____ Date _____