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. / Dr. / Rev. _____
Last First Middle Nickname or Preferred

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 _____

Parent/Guardian Date of Birth _____/_____/_____ SS# _____-_____-_____ e-mail _____

If student, grade level _____ School _____ Teacher _____

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

How will you be paying today? ☐ cash, check, or credit card ☐ Vision Insurance (VSP, Eyemed) ☐ Medical Insurance

"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

A few questions…

Were you referred here by another doctor? ☐ Yes ☐ No Who? _____

Are you allergic to any medications? _____

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.) _____

Thank You.