Welcome To Our Office

We Appreciate the Opportunity to Serve You!

Appointment Date____________________________

Patient Name____Marital Status_____________

If Child, Parent's Name____

Street Address____

City___________________________________State_______________Zip Code____________

Home Phone_________________Work Phone_________________Cell___________________

E-Mail Address____

Birth Date____________________Male or Female_____________SSN____________________

Preferred Language______________________Ethnicity________________Race_____________

Employer______________________________Occupation______________________________

Spouse's Employer____________________________Work Phone________________________

Health Insurance Carrier__________________________Policy Number___________________

Policy Holder's Name______________________________Birth Date_____________________

How did you find out about our office?____

Please list other family members who have visited our office_____________________________

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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 services are rendered (see payment policy sheet).

Signature____Date________________________