# WELCOME TO OUR OFFICE!

Thank you for choosing our practice for your eye care needs. So that we may better care for you, please fill out the following information. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help! All responses will be kept in strictest confidence.

Patient's Name: _____ Date: _____
FIRST MI LAST

PATIENT'S SSN: _____ ☐ Male ☐ Female Birthdate: _______________ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____ Home Phone: _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow\Widower

Patient's Employer or School: _____ Occupation or Grade: _____

Business Address: _____Work Phone: _____

Person To Contact In Case Of Emergency: _____ Phone # : _____

Whom May We Thank For Referring You To Us? _____

## RESPONSIBLE PARTY

Name Of Person Responsible For This Account: _____

Relationship To Patient: _____ SSN: _____ Phone # : _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone # : _____

## VISION INSURANCE INFORMATION \ PAYMENT AGREEMENT

Name Of Insured: _____ Relationship To Patient: _____

Birthdate: _______________ Insured's Social Security Number: _____

Name Of Employer: _____ Work Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____

Insurance Co. Address: _____City: _____ State: _____Zip: _____

I hereby authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and\or health practitioners. I authorize the use of this signature on all insurance submissions. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.
Our office honors Cash, Check, Discover, Visa, and Mastercard as payment. Professional fees are payable at the time of service. If eyewear or contact lenses are to be ordered, a minimum of 50% deposit is required and the balance is due upon delivery. A "prompt pay courtesy" is not available to those patients who have an insurance with which this office participates.

I have read and agree to all the provisions of the office financial policy.

Signature of patient (or parent if minor): _____ Date: _____

***CONTINUED ON BACK***