Welcome to Our Office

Appointment Date _____

Patient's Name (please print) _____
Last Name First Name Middle Name

If a Child, Parent/Guardian's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail Address _____

Birth Date _____ M or F SSN _____

Employer _____ Occupation _____

Spouse's Name _____ Date of Birth _____

Spouse's Employer _____ Work Phone _____

Health Insurance Carrier _____ Policy # _____

Medicare _____ Policy # _____

Vision Insurance Carrier _____ Policy # _____

Emergency Contact _____ Phone _____

How did you find out about our office? _____

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.

Signature _____ Date _____