DATE:____________

WELCOME TO OUR OFFICE! PLEASE TAKE A FEW MINUTES TO PROVIDE US WITH THIS INFORMATION.

PATIENT INFORMATION:

MR. MRS. MISS MS. DR.______________________________ BIRTHDATE______________

ADDRESS______________________ CITY______________ STATE/ZIP__________

PHONE/HOME______________ WORK____________ OK to phn work? ☐Y ☐N Cell PHN__________

E-MAIL ____________ Daytime Routine matters preferred contact method ☐work phn ☐e-mail message ☐ Home Phone

EMPLOYER____________________ OCCUPATION______________________

MARITAL STATUS **S M W** WHO MAY WE THANK FOR REFERRING YOU______________________

INSURANCE: PLEASE PRESENT INSURANCE CARDS WITH THIS FORM

VISION COVERAGE______________ 2ndary Vision Plan ______________

POLICY HOLDER if other than Patient______________ Sec Vis Policyholder ______________

Policyholder Birthdate __________ Polycyholder Birthdate __________

Vision Insurance ID # __________ 2ndry vision ID# __________

MEDICAL INSURANCE__________ Policyholder __________ Insured's birthdate __________

2ndary **Medical** Insurance __________ Policyholder__________ Insured's Birthdate__________

Medical Insurance ID# __________ 2ndry medical ins ID# __________

BILLING INFORMATION

RESPONSIBLE PARTY IF DIFFERENT THAN PATIENT______________________________

ADDRESS______________________ CITY______________ STATE________

ZIP CODE__________ PHONE NUMBER______________

I will pay my fees today by: (please circle) Check Cash Credit Card Debit Card

Optometric Services Fees

FEES FOR EYE EXAMINATION, EYE HEALTH EVALUATION & TREATMENT , AND CONTACT LENS EVALUATION SERVICES ARE DUE AT THE TIME THE SERVICE IS PROVIDED. For patients with insurance plans that we are participating, and or plans which we accept assignment, all co-pays are due same day.

Optical & Contact Lenses (patient pay and Non-Par Insurance**)**

50% DEPOSIT IS REQUIRED FOR EYEGLASS & CONTACT LENSES WHEN ORDERED. THE BALANCE IS DUE ON DISPENSING. Payment in full at time of order is required for special pricing and discounts.

INSURANCE PAR PLANS **All materials co-pays, lens options, and frame over allowable charges are due at time of order.**

A FINANCE CHARGE OF 1.5 % PER MONTH WILL BE ADDED TO BALANCES OVER 30 DAYS.

PATIENT SIGNATURE______________________________ **DATE**______________