

Welcome To Our Office!

Please complete the following to aid us in obtaining the necessary information for your visit.
(Yes, we know you hate to fill out forms, so we're going to make this as painless as possible.)

1. If you are a previous patient, and your address, phone and insurance information are the same, please check here and go to **PART 2**.
2. If you would like help, or have questions about this form, please inform the receptionist.

- Mr.
- Mrs.
- Ms.
- Miss

- Married
- Single
- Divorced
- Widowed

NAME _____ BIRTHDATE ___/___/___

ADDRESS _____ PHONE (home) _____

City _____ State ___ Zip _____ (work) _____

EMAIL _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

ADDRESS (If different from above) _____ City _____ State ___ Zip _____

HOW DID YOU HAPPEN TO CHOOSE OUR OFFICE? _____

PART 2

Please check all of the following areas that you would like more information on:

- Sunglasses
- Contact Lenses
- Eye Strain
- Laser Vision Correction
- Polarized Lenses
- Bifocal Contact Lenses
- Reading Problems
- Dry Eye
- Night Driving Lenses
- Eye Color Enhancement
- Vision Related Learning Problems
- Computer Glasses
- Safety/Sports Glasses
- Vision Training

Are there any other problems or concerns that you would like to bring to the doctor's attention?

FINANCIAL POLICY

PAYMENT IS DUE AT TIME PROFESSIONAL SERVICES ARE RENDERED. A 50% DEPOSIT IS REQUIRED BEFORE MATERIALS ARE ORDERED. BALANCE IS DUE UPON DELIVERY OF EYEWEAR AND CONTACT LENSES.

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance on my account for all fees incurred. I further understand that if I am eligible for insurance coverage, that my fees will be submitted for me as a courtesy if I provide the required information and forms.

SIGNED _____ DATE _____

Patient (or Guardian)

THANK YOU!

We look forward to serving you!