WELCOME TO OUR OFFICE

ACADEMY CONTACT LENS CLINIC
John M. Cavanagh, O.D.
and Associates

Date_____

Last Name_____ First Name_____ M.I._____
By what name would you like to be addressed? _____
Patient Date of Birth_____

Address_____
City_____ State_____ Zip Code_____
Home Phone (_____)_____ Work Phone (_____)_____
Cell Phone (_____)_____ E-mail _____
If under 18, parent/ guardian name(s)_____

Employer_____Occupation_____
If student, school name_____
Emergency Contact _____Phone (___)_____
Relationship to patient_____

Payment Policy: PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
Insurance information must be presented at time of service.

Referred by_____

WE APPRECIATE HAVING THE OPPORTUNITY TO PROVIDE YOUR VISUAL HEALTH CARE TODAY. IF WE CAN BE OF SERVICE TO YOUR FAMILY AND FRIENDS, YOUR REFERRAL IS MOST WELCOME.