CUSTOM EYES OPTOMETRY

Welcome Back to our Office

Today's Date: _____ / _____ / _____

Email:_____ Name**:**_____

Please let our office know if there are any changes in address and/or telephone numbers.

New Address: _____

_____

New Home Phone: _____Cell: _____ Work: _____

Medical Insurance: _____

If not self-insured, Subscriber Name: _____

Type of insurance. Choose one: ☐ PPO ☐ HMO ☐ POS ☐ Other _____

If HMO, name of HMO Medical Group:
☐ Greater Newport Physicians
☐ Memorial Care
☐ Monarch Medical Group
☐ Talbert Medical Group
☐ Other: _____

Please list all medication(s). If none, check here ❑ If no change since last time, check here ❑

_____

_____

_____

Do you have any allergies to medications? ❑ No ❑ Yes If yes, what medicines? _____

_____

ATTESTATION

I have read and understand, to the best of my knowledge, the above information. I certify that all statements are truthful and accurate. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that I am financially responsible for any service considered non-covered, any deductibles and/or co-payments as well as any service denied due to non-participating provider.

_____ _____
Patient or Parent or Guardian Signature Date

CERTIFICATION: ATTENDING PHYSICIAN HAS REVIEWED THE ABOVE MEDICAL/EYE HISTORY

_____ _____
Doctor Signature Date