WELCOME TO OUR PRACTICE

This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.

Patient's Name :_____
Last First Middle Nickname or Preferred

Please circle: Mr. Mrs. Ms. Miss. Dr. Rev.

Mailing Address:_____
Street or P.O. Box City State Zip

Date of Birth:____/____/____ SS#_____ Phone:_____-_____ _____-_____
Home Work

Mobile Phone_____-_____ E-mail Address_____

Your Employer_____Your Family Doctor_____

If married, name of spouse_____Spouse employed by_____

If under 18, parent or guardian's name_____Relation_____

Phone_____-_____Employer_____

If student, grade level_____ School_____

Why did you come to us?_____Who may we thank for referring you?_____

Where does the rest of your family go for eyecare?_____#in household_____

How will you be paying today? ☐Full payment by cash, check or credit card. ☐Vision Care Ins. with deductible.

Vision Insurance_____
Carrier name co-insurance/supplemental

Medical Insurance_____
Carrier name

"I request that payment of benefits be made to me or the doctor for any services provided by him"

_____
Signature Date

Your occupation & lifestyle play the most important roles in determining your visual requirements. How you will use your eyewear directly affects their performance. Please tell us about your lifestyle..

What is your occupation? _____How long?_____

What hobbies or activities do your enjoy?_____

What special vision needs do you have? (computer, overhead work, etc)_____.

Thank You.