Welcome to our office. In order to keep a current and accurate file of your eye care needs, the following information is requested of you.

Name:_____
Last First (legal) MI (Preferred nickname)

Date of Birth:_____ / _____ / _____
Marital Status: Single / Married / Widowed
Gender: Male / Female

Street Address: _____ APT #_____

Social Security #: _____

_____ _____ _____
City State Zip Code

Home telephone:_____

Email address: _____

Cell telephone: _____

Employer:_____ Occupation:_____
(Name of Business) (Please do not use abbreviations)

Business telephone:_____

Please check if it is okay for us to contact you via: text _____ email _____ phone _____

Preferred phone: home / cell / business

Ethnicity: Caucasian _____ American Indian _____ African American _____ Asian _____ Hispanic _____ Prefer not to answer _____

Approx. date of last eye exam:_____
Last eye doctor or location: _____
Do you presently wear glasses? _____
Do you presently wear contact lenses?_____
Are you interested in contact lenses today? _____

Approx. date of last physical exam: _____
Primary Physician or clinic:_____
Previous eye surgeries: (type & year) _____
_____
_____

Insurance policy holder, if different from above: (person responsible for payment)

Name: _____
Last First (legal) MI (Preferred nickname)

Social Security # _____

Street Address:_____ APT #_____

Date of Birth: _____ / _____ / _____

_____ _____ _____
City State Zip Code

Home telephone:_____

Business telephone:_____

Relationship to patient: _____ Gender: Male / Female

Employer: _____

Polycarbonate or **Trivex** lenses are the safest, most impact resistant spectacle lenses available and always the lens of choice for children, people with poor vision in one eye, people involved in sports or other activities involving danger of impact to their eyes. _____
initials

Contact lens care and handling is an important factor in your success with contact lenses. They must be worn and disinfected as recommended by the doctors or staff. If you have a problem with your contact lenses, remove them and notify us immediately.

Full payment is due at the time of service if no insurance information is provided or we are unable to accept your insurance. We may accept assignment of insurance benefits; however, we do require co-payment amounts to be paid at the time of service. Coverage amounts vary from policy to policy and we cannot guarantee the amount of coverage offered by your insurance carrier. It is your responsibility to seek coverage amounts and limits of liability on your insurance policy. You understand that your insurance policy is a contract between you and your insurance company. This office holds no party to that contract and will not be held responsible in the event your insurance company denies any claim. **In the event my insurance company denies payment, I agree to be personally and fully responsible for payment.** I authorize the release of any medical or other information necessary to process my insurance claim. I also request payment of government benefits to another party who accepts assignment.

In the event my account becomes past due, a finance charge of 3% per month will begin to accrue 30 days from the date of service or date of balance transfer from insurance. If my account is referred to an outside collection agency or attorney, I will be responsible for the collection costs (up to 33% of the balance due), along with reasonable attorney fees and court costs incurred by this office.

I certify that I have examined the above information and that it is true, accurate, and complete. I understand that any misrepresentation or concealment of information may subject me to liability.

I acknowledge that I was given an opportunity to read the Notice of Privacy Practices and was offered a copy.

_____ _____
patient signature / parent signature Date