

Welcome To Our Office!

Patient's Name _____

Date of Birth _____ Age _____

Patient's Social Security Number _____

Address _____

City _____ Zip Code _____

Telephone: Home _____ Cell _____

Business _____ Extension _____

If Child, Parent's Name _____

Telephone: Parent's Business _____ Cell _____

If Student, School _____

Teacher _____ Grade _____

Patient's Occupation _____

Employer _____

If Married, Name of Spouse _____

Spouse Employed By _____

Has any family member been a patient at this office? _____

If so, whom? _____

Whom may we thank for referring you to us? _____

Payment is expected when services are rendered, unless other arrangements are made in advance. Please indicate your preferred method of payment:

Cash/Check _____ Visa/Mastercard/Discover _____

If you have vision and/or medical insurance, please provide the necessary information needed for billing on the insurance information form. Please note, we are happy to submit a claim to your insurance company for you, however that does not guarantee payment will be made and you remain responsible for payment of all services and materials.

Member Name _____ Birthdate _____

Insurance Company _____ Member ID _____

Group Name _____ Group Number _____

Provider Phone # _____ Member Relationship to Patient _____