Welcome To Our Office!

Patient's Name ____ Age______

Date of Birth ____________________ Patient's Social Security # ____________________

Address ____

City ____ State ______ Zip Code ________

Telephone: Home _______________________ Cell ____________________________

Business _________________ Extension ________ Email________________________

Preference: □ Home □ Cell □ Business □ Other ________________________________

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? ____________________________________

Emergency Contact(s): Please list 2, if possible. Parents, please list one non-parent in case we cannot reach you.

Name ____ Relation ________________

Phone_____________________________

Name ____ Relation_________________

Phone_____________________________

Payment is expected when services are rendered, unless other arrangements are made in advance. Please indicate you 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_____________

Relation to Patient ____________________ Insurance Company______________________

Member ID __________________________ Provider Phone #______________________