Welcome to Our Office

For faster service, please complete the following form prior to arriving at our office.

Appointment Date _____

Patient's Name (please print) _____

If a child, Parent's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Email Address _____

Birth Date _____ Gender _____ SSN _____

Employer _____ Occupation _____

Spouse's Employer _____ Spouse's Phone _____

Health Insurance Carrier _____ Policy _____

Medicare/Medicaid_____ Policy_____

How did you find out about our office? _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____