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WELCOME TO OUR OFFICE

Thank you for choosing us for your eye care needs. In order to serve you properly, it is necessary for you to complete the following information and sign below. Please print.

First Name:	M.I.:	Last Name:	Birth date:	Sex: **M F**	Marital Status: **S M W D**
Street Address:			Home Phone #:		
City:	State:	Zip:	Work Phone #:		
Email address:			Cell Phone #:		
Ethnicity:	Language:	Pharmacy:			
Mother's Full Name (for Patients under 18):	Father's Full Name (for Patients under 18):				

Primary Insurance Company Name:	Subscriber # or ID #:	Group #:
Subscriber Name:	Subscriber Date of Birth:	Subscriber is: **Spouse** **Parent**
Do you have a Secondary Insurance Co.? **Yes** **No** Ins. Name:	Subscriber # or ID #:	Group#:
Name of Spouse:	Spouse's Date of Birth:	Do you have VSP or other vision plan? **Yes** **No**
Name of Spouse's Employer:		Spouse's Work #:

Name of person financially responsible for this account:		Phone #:
In case of Emergency, please contact:	Contact's Relationship to Patient:	Phone #:
Who referred you to our office?	Primary Medical Doctor Name & Phone #:	
How shall we contact you? Email Home Mail Work No Contact		
Please state the reason for your visit today:		

By signing below, I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I also authorize this office to provide me with reasonable and proper medical care by today's standards. I acknowledge their notice of privacy practices is available to me upon asking. I assign and request payment of medical and/or vision benefits directly to the physician for services rendered. This is to remain in effect indefinitely unless revoked in writing by the undersigned.

Patient, Parent or Guardian signature: ____ Date: ____________