



Bruce Wojciechowski, O.D., F.C.O.V.D.
John Reski, O.D.
Rachel Jorgensen, O.D.

15259 S.E. 82nd Dr., Suite 101 / Clackamas, Oregon 97015
503.657.0321 / Fax: 503.657.7066

9901 N.E. 7th Ave., Suite C115 / Vancouver, Washington 98685
360.546.2046 / Fax: 360.574.5576

www.doctorbruce.net

PATIENT INFORMATION

Date: _____

Welcome to our office!

Patient Name: _____ Date of Birth: _____

Address: _____ Contact #: () _____

City/State/Zip: _____ Email: _____

Parent/Guardian (if patient is a child) _____

Other children or siblings at home _____

Person responsible for payment (other than insurance) _____

Billing Address (if different): _____

Whom may we thank for referring you to our office?

Insurance Information

Vision Care Insurance

Name of Company _____ Phone # _____

Name of Insured _____ Date of Birth _____

ID# _____ Group # _____

Major Medical Insurance

Name of Company _____ Phone # _____

Name of Insured _____ Date of Birth _____

ID# _____ Group # _____

Payment Policy

Payment is due at the time of service. We accept cash, checks and all major credit cards. If you have insurance, we will be happy to bill the estimated portion your insurance plan covers; the remaining balance is due at the time of service. Your carrier is your best source of information regarding benefits and eligibility.

Signature _____ Date _____