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Welcome to our Office!
Patient Information

Patient Date of Birth: _____

Patient Name: _____ (Nickname) _____ Gender _____

Mailing Address: _____ City/State/Zip _____

Person responsible for payment : _____ Relationship_____ DOB: _____

Billing address: _____

Preferred phone number cell:_____ home:_____ work: _____

Email address: _____Preferred language: _____

Does this patient have any special needs we should be aware of? no___ yes _____

Ethnicity: (please choose one)
__ Hispanic/Latino
__ Not Hispanic/Latino
__ Unknown __ Declined

Racial Heritage: (please choose one)
__ Asian __ Native Hawaiian/Pacific Islander
__ White __ American Indian/Alaska Native
__ Declined __ Black or African American

Emergency contact:_____ **Relationship:** _____ **Phone:**_____

We appreciate you choosing our office! Whom may we thank for referring you to our office?
Name:_____ Relationship: _____
(If you have been referred by a medical provider/therapist we may be sending medical information regarding the patient)

INSURANCE INFORMATION:

Vision Insurance:

Company: _____ Policy Holder:_____

ID# _____ Group#_____ Policy Holder's date of birth: _____

Major Medical:

Company:_____ Policy Holder: _____

ID# _____ Group# _____ Policy Holder's date of birth: _____

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 _____