Welcome to our Office!

Patient Date of Birth: _____/_____/_____

Patient Name: _________________________ (Nickname) ____________________ Gender: M F X

Mailing Address: _____________________________________ City/State/Zip: ____________________________

Preferred phone: Cell: ( ) ______-_______ Home: ( ) ______-_______ Work: ( ) ______-________

Person(s) responsible for payment ___________________ Relationship: ____________ DOB: ____/_____/_____

Billing Address (if different): ____________________________ City/State/Zip: ___________________________

Email Address: ____ Preferred language: ______________________

Does the 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:

__ Asian
__ White
__ Declined
__Native Hawaiian/Pacific Islander
__ American Indian/Alaska Native
__ 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: ________________________

Insurance Information

Vision Care Insurance: □ None
Name of Company __________________________________ Phone # _______________
Policy Holder ___________________________________ Date of Birth _____/_____/_____
ID# ______________________________________ Group # ______________

Major Medical Insurance: □ None
Name of Company __________________________________ Phone # _______________
Policy Holder ___________________________________ Date of Birth _____/_____/_____
ID# ______________________________________ Group # ______________

Payment Policy:

Payment is due at the time of service. We accept cash, checks and all major credit cards including care credit. 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.

Signature ____ Date ___________________