WELCOME TO OUR OFFICE

Last Name _____ **First** Name (Legal) _____Nickname _____

Street Address _____ City _____ Zip Code_____

Home Phone _____ Cell Phone_____ Work Phone _____

Birth Date _____ Social Security # _____ E Mail Address_____

Employer Name & Address _____ Occupation_____

Name of Spouse _____ If you're a child, Parent's (Guardian's) Name _____

Responsible Billing Party _____ Relationship to Patient _____

(Please Circle Appropriate Response)

Preferred Language: (English, Spanish) Salutation (Mr., Mrs., Ms., Dr., Other _____)
Sex… (Male/Female) Marital Status… (Single, Married, Widowed, Divorced, Other)
Race: (White, American Indian, Alaska Native, Asian, Black/African American, Hispanic, Native Hawaiian/Pacific Islander)

VISION INSURANCE INFORMATION

Primary Carrier _____ **Secondary Carrier** _____

Insured Name _____ Insured Name _____

Insured Birth Date _____ Insured Birth Date _____

Insured ID # _____ Insured ID# _____

Patient's Relationship to Insured _____ Patient's Relationship to Insured _____

Are you a full time student? (YES/NO) If yes, does your insurance company have proof of student status? (YES/NO)

MEDICAL INSURANCE INFORMATION

Primary Carrier _____ **Secondary Carrier** _____

Insured Name _____ Insured Name _____

Insured Birth Date _____ Insured Birth Date _____

Insured ID # _____ Insured ID# _____

Patient's Relationship to Insured _____ Patient's Relationship to Insured _____

Are you a full time student? (YES/NO) If yes, does your insurance company have proof of student status? (YES/NO)

OTHER INFORMATION

Whom may we thank for referring you? _____ Is it ok to use dilating drops? (YES/NO)

If for any reason my insurance does not pay as expected, I am responsible for the balance.

Signed _____ Date _____