Welcome to our office. Please fill out completely **Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: Last: | First: | MI: | You go by: |
| Address: | City:  | State: | Zip: |
| Phone: Primary | Alternative #:  | Sex: | D.O.B: / /  | Age: |
| Employer: | Location: | Employer phone #: | SSN: |
| We use an automated service for appointment reminders, recall etc. Please provide a valid emailEmail: |
| For Minors: Guardian | Relationship: | Contact Number: |
| How did you hear about our office: |

**INSURANCE INFORMATION:**

Primary Care Doctor Information:

|  |  |
| --- | --- |
| NAME: | PHONE: |

Please list your Routine Vision Insurance:

|  |  |  |
| --- | --- | --- |
| Name: | Primary Member info: Name:DOB:SSN: | ID#:Group#: |

 Please List your Primary Medical Insurance:

|  |  |  |
| --- | --- | --- |
| Name: | Primary Member info:Name:DOB:SSN: | ID#:Group#: |
| Our office policy:~ We require payment for the eye exam/office visit as services are rendered. If glasses or contacts are ordered, we require at least one half down when the order is placed and the balance is due upon pick up/dispensing.~ If we are participating providers with your insurance, we will accept payment from them, and will submit their portion to them. If you have an insurance that we are not providers for, we ask that you pay us in full and we will give you a receipt for you to submit for out of network benefits.~ We accept these forms of payment: Cash, Check, MasterCard, Visa, Discover, Care Credit~ I authorize the release or any information necessary to determine my insurance benefits. I understand that I am financially responsible for any charges not covered by my insurance. ~ I acknowledge that I was offered a copy of the *Notice of Privacy Practices* in accordance with the HIPAA Act of 1996Please sign here that you have read and understand the above statements:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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