Welcome to Our Office

This information will allow us to begin the process that ensures your eye health and vision remain at their best, and that your health and lifestyle needs are met. Thank you for your help.

Your Name Miss / Mrs. / Ms. / Mr. / Dr. / Rev. _____
Last First Middle Nickname or Preferred

Your Address _____
Street or P.O. Box City State Zip

Your Date of Birth ____/____/____ SS# ____-____-____ Phone ____-____ ____-____
home work

Your Employer _____ Your Family Doctor _____

If married, name of spouse _____ Spouse employed by _____

If under 18, parent or guardian's name _____

Relation _____ Phone ____-____ Employer _____

If student, grade level _____ School _____ Teacher _____

Why did you come to us? _____ Who may we thank for referring you? _____

Where does the rest of your family go for eye care? _____ # in household _____

How will you be paying today? ☐ Full payment by cash, check, or credit card ☐ Vision Care insurance with deductible
☐ Full payment for professional fees, deposit on eyeglasses, balance paid on dispensing

Vision Insurance _____
carrier name

Medical Insurance _____
carrier name co-insurance/supplemental

"I request that payment of benefits be made to me or the doctor for any services provided by him. I also authorize any holder of medical information about me to release to the carrier and its agents any information needed to determine these benefits or the benefits payable for related services."

_____
signature date

Your occupation and lifestyle play the most important roles in determining your visual requirements.

Tell us about your lifestyle ...

What is your occupation? _____ How long? _____

What hobbies or activities do you enjoy? _____

What special vision needs do you have? (computer, overhead work, etc.) _____

, olycarbonate lenses are the most impact resistant lenses available and are the safest for children and/or sports. _____
Your Initials

Thank You.