

PATIENT INFORMATION

Patients Legal Name: _____

Preferred Name: _____

Patient's Date of Birth: ____/____/____ Patients Social Security No.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse or Legal Guardian: _____ Date Of Birth: _____

(For insurance purposes only)

Spouse/Legal Guardian Social Security No.: _____

(For insurance purposes only)

CONTACT INFORMATION

Home No.: _____ Work No: _____

Cell No.: _____ E-Mail Address: _____

Occupation: _____

Employer Name: _____ Address: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Name of Medical Insurance: _____

Member ID: _____ Policy Holder Name: _____

Name of Vision Insurance: _____

Member ID: _____ Policy Holder Name: _____

Primary Care Physician's Name: _____

Referral Information—How did you learn about office? _____

If you were referred by a current patient, whom may we thank? _____

This is a legally binding contract for fees. Professional services, glasses, or contact lenses are to be paid upon services rendered. All other payment arrangements must be made in advance.

Unpaid insurance is the responsibility of the patient/bill payer and will be billed accordingly at 90 days.

I understand that in the event any unpaid balance is placed for collection, with any 3rd party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, all collections costs, attorney fees, filing fees, interest and court costs will be added to the total amount due.

Patient's Signature/Legal Guardian _____ Date _____