

Patient Information

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Birthdate _____ Age _____ SEX (circle one) male female
Patient Social Security Number (required) _____
Employer _____ Occupation _____

Insurance Information

Name of insurance that provides vision benefits _____
Name insurance is under (Insured) _____
Plan ID number (if applicable) _____
Social Security Number of Insuree _____
Birthdate of Insured _____ Relationship to patient (circle one) Spouse Parent Self
Are you planning on getting new glasses or contacts today? (Please circle one below)
Glasses Contacts Both Only if change in prescription

Payment Policy

We require payment in full on glasses and contacts prior to ordering. You are responsible for ANY balance, which is not paid by your insurance. If for any reason it is necessary to turn your account over to a collection service or attorney, you will be responsible for any additional charges, including a \$75.00 office fee.

Signature _____ Date _____