PATIENT INFORMATION

Patient: _____ Sex: M F Birth Date: _____ Age: _____

Social Security #: _____ Driver's License #: _____ State: _____

Home Address: _____

City: _____ Zip Code: _____

Home Phone: ( ) _____ Business Phone: ( ) _____

Cell Phone: ( ) _____ E-Mail: _____

Occupation: _____ Employer/School: _____

Spouse's Name: _____ Birth Date: _____ Age: _____

[Emergency] Name: _____ Phone: ( ) _____

DISCLAIMERS

(A.) **Payment in Full:** When services are rendered and when products (eyeglasses, contacts, etc.) are ordered.

(B.) **Insurance Plans:** Our staff will assist you in determining what portion of your care may be covered by your insurance. Any portion of the account not payable directly to our office by your insurance company will be paid by patient at the time services are rendered or patient will be billed.

(C.) **Policies: * Progressive lens non-adapt:** If adaptation to progressive lenses is not made within 60 days, we will remake the lenses to either single vision or lined bifocals as a courtesy, but no refund will be granted.

* **Money Back Guarantee:** If satisfaction is not achieved with your glasses, a refund, less service charges, will be given, up to 60 days after delivery.
* **Unclaimed Product:** If product (eyeglasses, contacts, etc.) are not picked up by 90 days after first notification that they are ready, they will be returned with NO REFUND issued to patient.
* **Patient's Own Frame**: We are not responsible for breakage of your frame when new lenses are inserted.

(D.) **Financial Responsibility:** This information is accurate and true to the best of my knowledge. Payment is due when service is rendered. In the event that benefits are not paid by my insurance carrier, the entire balance is my responsibility. I am responsible for deductibles, co-pays, and charges that my insurance does not cover. I understand that I am responsible to pay for services rendered, including costs of collection and interest, in the event of default.

(E.) **Copies:** If records are requested, we require a minimum 72 hour grace period to process records.

* **Contact Lens Services: All contact lens services, including contact lens prescriptions, are distinct and separate from the routine (eyeglass prescription) eye exam. Charges for these services are separate.**

Please sign... (if patient is under 18, must be signed by parent or guardian to authorize treatment.)

Signature: _____ **Date:** _____

(Please read and fill out other side of this form)

BILLING INFORMATION

(ALL information below is needed for billing your insurance)

Member's Name:_____D.O.B.:_____S.S.#_____

Vision Insurance:_____ Plan #: _____

Medical Insurance:_____ Plan #: _____

Family Physician:_____ City: _____ Phone: ( ) _____

MEDICAL HISTORY

Are you **taking** any medications? ***(circle)*** yes no Please list: _____

Are you **allergic** to any medications? ***(circle)*** yes no Please list: _____

Do you now or have you ever had any eye disease, injury or surgery? ***(circle)*** yes no

Please explain: _____

Do you, or any of your blood relatives, have….?

High blood pressure; *who?* _____ Heart disease; *who?* _____

Diabetes; *who?* _____ Asthma/Lung Disease; *who?* _____

Thyroid disease; *who?* _____ Glaucoma; *who?* _____

For women: Are you now, or do you think you may be pregnant? ***(circle)*** yes no

REASON FOR YOUR VISIT

I am here today for: ***(circle)*** glasses, contact lenses, Eye Problem/Infection

Briefly state any vision / eye problems: _____

_____

_____

Date of last eye exam: _____ Have your eyes been dilated before? ***(circle)*** yes no

Do you wear contact lenses? ***(circle)*** yes no Type of contact lenses? ***(circle)*** Hard Soft

(Please read and fill out other side of this form)