OFFICE ID:

LAST NAME

FIRST NAME INITIAL

NICKNAME

HOME PHONE

WORK PHONE

CELL PHONE

HOME ADDRESS

CITY

STATE ZIP

REFERRED BY

BIRTHDATE

SOCIAL SECURITY

EMPLOYER

OCCUPATION

SCHOOL: GRADE:

VISION INSURANCE

MAJOR MEDICAL INS.

Has anyone in your family been seen at this office: YES NO

		check column			*check column*		
TODAY'S DATE / /		**RETURN VISIT DATE / /**			**RETURN VISIT DATE / /**		
MEDICATION	TREATMENT FOR	CONTINUE	DISCONT	ADDED	CONTINUE	DISCONT	ADDED

PERSON RESPONSIBLE FOR PAYMENT: (SIGNATURE) _____

Payment for all professional services are required at the time the services are rendered. If ophthalmic materials are prescribed, a deposit is required before the material is ordered. The balance is to be paid in full at the time they are dispensed. You will be reponsible for any payment not paid by your insurance. We accept cash, check, M/C, VISA, & Discover.