PATIENT INFORMATION

LAST FIRST M.I. ______________ HOME PHONE ______________ BIRTHDATE ______________

MAILING ADDRESS ______________ SOCIAL SECURITY # ______________

CITY STATE ZIP ______________ SPOUSE NAME ______________

EMPLOYER______________ OCCUPATION______________ WORK PHONE ______________

APPROXIMATE DATE OF LAST EYE EXAM: ______________ EYE DOCTOR ______________

ARE YOU TAKING ANY MEDICATIONS OR BEING TREATED FOR AN ILLNESS? IF SO, WHAT KIND?

____

LIST ANY MEDICATION ALLERGIES:______________

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE:
DIABETES ________ HIGH BLOOD PRESSURE ________ CATARACTS ________
GLAUCOMA ________ MACULAR DEGENERATION ________
OTHER EYE DISEASES ______________

DO YOU OR HAVE YOU EVER WORN GLASSES OR CONTACTS? Yes No

ARE YOU A MEMBER OF ONE OF THE FOLLOWING VISION INSURANCES?

VISION SERVICE PLAN (VSP) ____ DAVIS VISION ____ P5 ____
BENEFIT PLANNERS (STATE OF NV PPO) ____ MEDICAL EYE SERVICES (MES) ____

PRIMARY CARDHOLDER ______________ SSN ______________

IF PATIENT IS A MINOR, PERSON RESPONSIBLE FOR FINANCIAL PAYMENT OF THIS ACCOUNT.
NAME ______________ RELATIONSHIP ______________
EMPLOYER ______________ SSN ______________ WORK PHONE ______________

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE PROVIDED. WE ACCEPT CASH, CHECK, MASTERCARD/VISA, DISCOVER, AMERICAN EXPRESS, AND ATM CARDS.
A 50% DEPOSIT IS REQUIRED ON ALL MATERIALS ORDERED.
THERE IS A $25 CHARGE FOR ALL RETURNED CHECKS.

<u>*BALANCES ARE DUE AT THE TIME MATERIALS ARE RECEIVED*</u>

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES NOT COVERED BY ASSIGNMENT. BY SIGNING BELOW I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO UNDERSTAND WHAT INSURANCE COMPANY I HAVE, AND WHAT BENEFITS ARE COVERED BY MY INSURANCE COMPANY TOWARDS SERVICES AND MATERIALS.

______________ ______________
SIGNATURE OF RESPONSIBLE PARTY DATE