PATIENT INFORMATION

LAST FIRST M.I. DAY TIME PHONE CELL PHONE

MAILING ADDRESS E-MAIL BIRTHDATE

OK TO CONTACT VIA E-MAIL

CITY STATE ZIP SPOUSES NAME

EMPLOYER OCCUPATION WORK NUMBER

DATE OF LAST EYE EXAM PREVIOUS EYE DOCTOR

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

LIST ANY MEDICATION ALLERGIES:

HAVE YOU EVER BEEN DIAGNOSED WITH:

DIABETES HIGH BLOOD PRESSURE CATARACTS

GLAUCOMA MACULAR DEGENERATION

OTHER EYE DISEASES

DO YOU OR HAVE YOU EVER WORN GLASSES: YES NO CONTACTS: YES NO

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

VISION SERVICE PLAN(VSP) DAVIS VISION

CDS MEDICAL EYE SERVICES(MES)

PRIMARY CARDHOLDER SSN:

IF PATIENT IS A MINOR, PERSON RESPONSIBLE FOR FINANCIAL PAYMENT OF THIS ACCOUNT.

NAME RELATIONSHIP DATE OF BIRTH

EMPLOYER SSN WORK NUMBER

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE PROVIDED. WE ACCEPT CASH, CHECK, ALL MAJOR CREDIT CARDS AND DEBIT CARDS.

A 50% DEPOSIT IS REQUIRED ON ALL MATERIALS ORDERED.

THERE IS A $25 CHARGE FOR ALL RETURN CHECKS.

******BALANCES ARE DUE AT THE TIME MATERIALS ARE RECEIVED******

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: