Welcome To Our Office!

Patient Information:		
Name:		Patient Birth Date (mm/dd/yyyy):
Address:		
City:	State:	Zip:
E-Mail:		
Primary Phone #		Alternate Phone #

What are you interested in today? (Please Check One)
Eye Exam |__| Contact Lens Fit/Re-fit |__| Full Services (Including Eye Exam and CL Services) |__|

Primary Insurance Information:	
Insurance ID #	
Subscriber Name:	Birth Date:
Relationship to Subscriber (Please Circle One): Self Spouse Dependent Child	
Eye Exam Co-pay:	CL Fit/Re-fit Co-pay:
Insurance Auth. #:	

Secondary Insurance Information:	
Insurance ID #	
Subscriber Name:	Birth Date:
Relationship to Subscriber (Please Circle One): Self Spouse Dependent Child	
Eye Exam Co-pay:	CL Fit/Re-fit Co-pay:
Insurance Auth. #:	

**I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible for all charges not covered by my insurance.

Patient Name (Please Print):	**Date:**
Patient Signature:	