PATIENT INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____

Gender: M F Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ State: _____
Zip Code: _____

Employment: Full-Time | Part-Time | Self-Employed | Retired | Not Employed | Student | Military

Marital Status: Married | Single | Divorced | Widowed | Legally Separated

Race: American Indian or Alaska Native | Asian | Black or African American | European | Hispanic | Native Hawaiian or Other Pacific Islander | White

Home Phone #: _____ Cell Phone #: _____

Communication Preference: Telephone Postal Email: _____

RESPONSIBLE PARTY

First Name: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

Social Security #: _____ Date of Birth: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder Name: _____
Policy Holder DOB: _____ Patient Relationship to Holder: _____
Insurance ID #: _____ Group #: _____

POLICY FOR EYEWEAR AND CONTACT LENSES

All sales of prescription and non-prescription eyeglasses, sunglasses, and contact lenses are FINAL! If there is a need for the prescription to be adjusted, such changes are included at no charge for a one-time redo within 90 days of purchase. All eyeglasses and contact lenses that have been prescribed, fitted, and purchased by the patient will be kept in the office for a total of 6 months from the date of purchase. If the patient does not pick them up within that time frame, they will be donated to charity and no refund will be issued.

PERSONAL CHECKS AND BOUNCED CHECKS

Any bounced personal check is subject to a fee of $35, which is to be paid, in addition to the original amount, within 30 days. After the 30 day period has expired the check will be turned over to the county attorney for collection.

By signing below, you are agreeing to have read and understood all aspects of the above policies.

Patient Signature: _____

Date: _____