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**Patient Personal Information**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Employer \_\_\_\_\_  
 Last Name \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent/Guardian \_\_\_\_\_  
 Sex: M / F    Marital Status: S / M / D / W    Emergency Contact \_\_\_\_\_  
 Emergency Phone \_\_\_\_\_  
 Primary Care Office w/Location: \_\_\_\_\_  
 Pharmacy w/Location: \_\_\_\_\_

**E-MAIL & TEXT NOTIFICATIONS!!**

- On-line Appointment Requests
- Text Notifications of Completed Orders
- Appointment Confirmations
- Text Message Appointment Reminders
- Satisfaction Surveys

***By providing this information you are consenting to receive email and/or text messages.***

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

**Patient Insurance Information:** Relationship to Insured:  Self  Spouse  Child

Medical Ins. Carrier \_\_\_\_\_  
 ID# \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_  
 Policy Holder's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy Holder's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Vision Ins. \_\_\_\_\_  
 ID# \_\_\_\_\_  
 Group # \_\_\_\_\_  
 Policy Holder's Name \_\_\_\_\_  
 Policy Holder's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy Holder's SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_



**Do you have a family medical history of any of the following:**

- Glaucoma             yes  no      Relationship: \_\_\_\_\_ (Maternal / Paternal)
- Lazy Eye             yes  no      Relationship: \_\_\_\_\_ (Maternal / Paternal)
- Macular Degeneration     yes  no      Relationship: \_\_\_\_\_ (Maternal / Paternal)
- Color Blindness         yes  no      Relationship: \_\_\_\_\_ (Maternal / Paternal)
- Other Vision History \_\_\_\_\_

**Preferred Language:**

- English
- Spanish

**Race:** (Please indicate all that apply below)

- White
- American Indian or Alaskan Native
- Asian
- African American
- Hispanic
- Native Hawaiian or Pacific Islander

**Ethnicity:**

- Not Hispanic or Latino
- Native Hawaiian/ Other Pacific Islander

**Communication Preference:**

- Email
- Text
- Mail
- Telephone

**Referred by:**     Patient: \_\_\_\_\_     Professional: \_\_\_\_\_     Other: \_\_\_\_\_

**Contact Lens Management (for current wearers only):** For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee is charged beyond the comprehensive eye examination. We determine fit, health and the condition of the eyes while wearing contact lenses. We also evaluate changes in prescription and lens design during this process. **Soft contact lens evaluation and new prescription is \$55; refitting to a new brand of contact lens will cost between \$85 and \$249, depending on the type of soft lens being fit. The fees for Custom or RGP contact lens evaluations and refits vary. Please ask the Staff or your Optometrist for details.**

**Financial Responsibility & Benefits Coverage**

I understand that the doctor(s) may or may not be participating with my insurance carrier and I am fiscally responsible for all charges whether paid by my insurance company. I give my permission to bill my insurance company with the understanding that I am responsible for all charges whether paid by my insurance carrier. I understand that I am responsible for and aware of my eyewear benefits coverage and it is my responsibility to make that information known at time of purchase. I understand that I will forfeit such benefits if they are provided after merchandise has been completed and/or provided. I understand that **the fee for returned checks is \$50.00, and the fee for a missed appointment without 24-hour notice is \$50.00.**

**Please sign below that you have reviewed all of the information above, and it is correct to the best of your knowledge.**

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_  
(Required)