

Welcome to Our Office

Please take a few minutes to complete this form. This information is confidential and will not be released without your consent.

Today's Date ____ / ____ / ____

Name _____ Nickname _____

(First, Middle Initial, Last)

Address _____ City _____ State _____ Zip _____

Occupation _____ If Married, Name of Spouse _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Date of Birth _____ Age _____ Sex M F Referred by _____

If the patient is not the person responsible for the bill please complete this section.

If Minor – Name of Parents _____

Mother's Work Phone _____ Father's Work Phone _____

Name of School _____ Grade _____ Teacher _____

Responsible Party _____

Address _____ City _____ State _____ Zip _____

What is the nature of this appointment? _____

Date of last visual exam ____ / ____ / ____ Doctor _____

What was prescribed/told to you? _____

Spectacles used presently? Yes No How old? _____ When used? _____

Contact Lenses used presently? Yes No How old? _____ When used? _____

Type of contact lenses: circle hard gas perm soft toric bifocal

Previous eye disease/injuries/surgeries _____

Current medications _____

Sports, hobbies, interests _____

Do you or any of your relatives have a history of:

You	Relatives (specify)	You	Relatives (specify)
_____	Glaucoma _____	_____	High Blood Pressure _____
_____	Cataracts _____	_____	Heart Condition _____
_____	Diabetes _____	_____	Thyroid Condition _____
_____	Blindness _____	_____	Head Injuries _____
_____	Eye Turn _____	_____	Allergies (explain) _____

Other _____

Please Continue on Other Side

Policy

- *Payment in full* is due when services are rendered, regardless of insurance coverage.
- *Our office is not a participating provider in any insurance plans. We will provide an itemized statement which you can submit to your insurance.*
- All contact lenses must be paid in full prior to dispensing and cannot be returned after the fitting period.
- When purchasing glasses from Niwot Optical, their policy is 50% deposit when ordering and remaining 50% due upon dispensing.
- Medicare: This office is a non participating provider therefore payment is expected when services are rendered. As a courtesy we will submit one claim to Medicare following your visit to our office. However, we cannot guarantee payment on your claim.
- I have read and agree to these office policies.

Signature (Parent or guardian if minor)

Date