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: We DO NOT file Medicare or Medicare Supplemental policies. Please let us know if you would like to cancel this appointment due to this policy.

- I have read and agree to these office policies.

_____ _____

Signature (Parent or guardian if minor) Date