Welcome to Our Office!

Please fill out the form below and bring it with you when you come in for your appointment.

Today's Date: ____________________

General Information					
Patient's Name	First		Last		MI
Address					
City		State		Zip	
Home Phone	( ) -	Work Phone	( ) -	Cell Phone	( ) -
Social Security No.		Birth date			
Place of Employment		Occupation			
Name of Spouse		Email Address			
Insurance Information					
Name of Policy Holder	First		Last		MI
Date of Birth		Social Security No.			
Contact #	( ) -	Relationship to Patient			
Address					
City		State		Zip	
Emergency Contact Name and Number	( ) -				
How did you hear about us?					

INSURANCE

Please give all Vision and Medical Insurance cards to the receptionist upon arrival

PLEASE NOTE:

It is the patient's responsibility to know if they are covered by their insurance plan for **"Routine Vision." Contact lens fittings are usually not covered by insurance.** Be prepared to pay any additional cost for the service. The patient is responsible for all fees regardless of insurance. **There is a separate copay or charge for the Contact Lens fitting.**

Are you wearing contact lenses? (circle one) YES / NO
Are you interested in wearing Contact Lenses? YES / NO
Are you interested in LASIK procedure? YES / NO

Reason for today's visit: ____________________

How were you referred to our office? ____________________

I request that payment of authorized Medicare benefits or other insurance be made directly to Champion Eye Center and its affiliated Doctors for any services furnished to me. I authorize any holder of medical of medical information about me be released to the health care financing administration and its agents, as well as any information necessary to determine the benefits payable for related services.

Patient Signature: ____________________

Date: ____________________