Patient's Name _____ Today's Date _____
Social Security # _____ Age _____ Date of Birth _____
Address _____
ZIP _____ Phone _____ Fax _____ Email _____
Name of spouse _____ or parent _____
Occupation or school grade _____
Employer _____ Phone _____
Address of employer_____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

Preferred payment method: CASH (discount available) _____ ***CHECK*** _____ ***VISA*** _____ ***MASTERCARD*** _____

Current Davis ID Number _____ **You must provide your Davis ID info or we CANNOT bill your plan. You will need to pay us and obtain your benefit from Davis yourself.**

What is the copay?_____
If you wear contact lenses, will you use your benefit towards glasses **or** contacts?_____
If contacts, list your contact lens exam and material benefit per your plan:_____ exam_____materials
Please note: **Insurance companies cannot be named as a responsible party for the services and products you receive. We can bill a carrier that we have a participation agreement with for services they cover. However, you are ultimately responsible if they refuse payment to us**.
Do you want drops used to dilate your eye pupils? YOUR VISION WILL BE BLURRED
Only if the doctor feels that it is needed _____ No _____ Yes _____
Are you interested in new contact lenses at this time? _____

Approximate date of last eye examination _____ By Doctor _____
Do you feel that your vision problems occur: At Distance? _____ At near? _____
Have you ever worn contact lenses ? ____ If so, when? _____
Type of contacts worn _____ Care solutions used _____
Have you ever received vision training or eye exercises? _____
HISTORY: check any that you now have or ever had

_____ ALLERGIES	_____ HEART DISEASE	_____ EYE OR HEAD INJURIES
_____ DRUG SENSITIVITIES	_____ HIV+ OR AIDS	_____ CATARACTS
_____ DIABETES	_____ SEIZURES	_____ GLAUCOMA
_____ HIGH BLOOD PRESSURE	_____ EYE DISEASES	_____ HEADACHES

FAMILY HISTORY (Blood relatives who have the following):

_____ DIABETES	_____ GLAUCOMA	_____ CATARACTS
_____ EYE DISEASE	_____ BLINDNESS	_____ HEART DISEASE

Family physician & address _____
List any conditions that you are presently being treated for: _____
_____
Please list ALL MEDICATIONS you are presently taking_____
_____
Who may we thank for referring you to our office? _____
List anyone to whom we may release your information_____
List your health care insurance provider _____ ID #_____

"I request payment of authorized health care benefits be made either to me or on my behalf to E. Wagman, OD for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based on the charge determination of the Medicare carrier."

Beneficiary signature
_____Date_____