Patient's Name _____ Today's Date _____
Social Security # _____ Age _____ Date of Birth _____
Address _____
ZIP _____ Phone _____ Fax _____ E@mail _____
Name of spouse or parent _____
Occupation or School grade _____
Employer _____ Phone _____
Address of employer _____

- 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: list any significant medical or eye history, including family history _____
_____
_____
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? _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED.

Preferred payment method: CASH (discount available) _____ CHECK _____ VISA or MASTERCARD _____
WHO WILL PAY FOR THIS ACCOUNT? (Self**? _____)** or Name _____
Address _____

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. Name of "insurance"company _____**

Vision Plan Name _____ID # _____ Group # _____
If you will use your insurance as a form of payment to us, you must present current insurance ID information to us no later than at the time of your appointment; if your vision plan is not listed on your insurance card, you must inform us of the vision plan's name so we can attempt to determine your coverage. If you have not presented your insurance information prior to the start of your examination, we will not be able to provide refunds, cancellations, or adjustments to fees; however, we will help you submit your claim for reimbursement.

Will you submit any of your bill to Medicare? _____ Medicare ID # _____

Co-insurance company & ID # _____
"I request payment of authorized Medicare 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."

Signature _____ Date _____

List anyone to whom we may release your information _____