

Welcome To Our Office!

Please fill out the following information, so we may better serve you. Thank you for your cooperation.
Today's date _____

MINOR PATIENT

Full Name _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____ Email _____

Gender: Male Female Name of School Attending _____

Primary Doctor's Name _____ Phone # _____

Residing with: both parents, mother, father, guardian

MOTHER

Salutation _____ Full Name _____ Birth Date _____

Address _____ Phone _____

Employer _____ Phone _____

Social Security # _____ Responsible Party for billing Yes No

FATHER

Salutation _____ Full Name _____ Birth Date _____

Address _____ Phone _____

Employer _____ Phone _____

Social Security # _____ Responsible Party for billing Yes No

INSURANCE

Check if we copied your insurance card(s) then proceed to the questions below.

Primary Insurance Plan _____ Insured's Name _____

Second Insurance Plan _____ Insured's Name _____

How did you find out about our vision services? _____

Whom may we thank for referring you? _____

What is your main concern about this visit today? _____

Are other family members patients here? _____

How do you plan to pay any remaining balance your insurance doesn't pay? _____

If there is anyone involved in your payment plan that is not mentioned above please provide name, address, phone number, place of work and insurance (if any) on the back of this paper.

RELEASE I assign payment to and authorize Love Your Face Optical to file a claim with my insurance for payment of services or to accept assignment of any government benefits due to my child. I authorize the release of all information necessary to process these claims. I understand if it is later determined that my child is not eligible to receive benefits for these services, I will personally be responsible for payment to Love Your Face Optical.

(Signature of Parent or Legal Guardian)

(Date)

(Print Name)