Welcome To Our Office!

Please fill out the following information, so we may serve you better. Thank you for your cooperation.

Today's date _____

PATIENT

Full Name _____Date of Birth_____ Age_____

Address_____ City _____ State ____ Zip _____

Home Phone #_____Cell Phone #_____ (Circle # to contact for appointments)

E-Mail _____

Marital Status: Married _____, Single_____, Divorced _____, Widowed _____, Separated _____

Student Full Time_____ Part Time_____

Place of Employment_____Work#_____

Patient's Social Security #_____

Primary Doctor's Name _____ Phone #_____

GUARANTOR ____ **Check if same as patient. Skip to Insurance.**

Full Name_____ Date of Birth_____

Address _____Phone_____

Employer_____ Work#_____ Social Security_____

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

Primary Insurance Plan_____

Insured's Name_____ Date of Birth_____

Secondary Insurance Plan_____

Insured's Name_____ Date of Birth_____

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? Name(s)_____

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 following lines: _____

_____

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 me. I authorize the release of all information necessary to process these claims. I understand if it is later determined that I am not eligible to receive benefits for these services, I will personally be responsible for payment to Love Your Face Optical.

_____ _____

(Patient or Legal Guardian Signature) (Date)

_____(Print Name)