

WELCOME TO THE PROFESSIONAL EYE CARE CENTER!

Title: Name _____
___ Mr. (Last) (First) (Middle)
___ Mrs. Address _____
___ Ms. City/State/ZIP _____
___ Dr. Telephone (home) _____ (work) _____
(cell) _____

Age _____ Date of Birth _____ Gender _____

Employer _____ Occupation _____

Social Security Number (for insurance billing/authorizations) _____

Referred by (We'd like to say thank you!) _____

Are you interested in any specific type of contact lens? Please check:

___ Soft disposable ___ 1-day disposable
___ Gas permeable ___ Astigmatic soft lenses
___ Lenses that change eye color ___ Bifocal contact lenses

Are you interested in learning more about laser vision correction? ___ Yes ___ No

Please list your hobbies, sports and special interests: _____

If you wish to receive our monthly newsletter by email, please provide your current email address. This is for information purposes only and is never given to any other party: _____

OFFICE POLICY

It is customary to pay for all services as they are rendered. Please be prepared to pay for all co-payments today with cash, check or credit. There is a \$25.00 billing fee if the exam co-payment is not paid today. There is a \$35.00 fee for returned checks.

Professional fees for services, spectacles and contact lenses are non-refundable.

Whenever possible, kindly give 24 hrs. notice when canceling appointments.

Signature _____