

Welcome to Our Office

Date: _____

Preferred Name: _____

PLEASE COMPLETE OR CORRECT THE FOLLOWING INFORMATION:

Patient's Name: _____ Age: _____ DOB: _____

Address: _____

Communication Preference _____

Telephone: (Home) _____ (work) _____ Cell phone) _____

E-mail Address: _____ Social Sec #: _____

Occupation: _____ Employer: _____

Names and ages of children: _____

Spouse's Name: _____

Responsible Party for Account: _____ Address: _____

Smoker? Please circle one: Current Former Never

Primary Reason for today's visit? _____

Date of last eye examination _____ Name of Physician _____

Are you presently being treated for any medical conditions? _____

If so, what conditions? _____

Please list present medications _____

Any special occupational or recreational vision needs? _____

Would you like to wear contact lenses? _____ What type? _____

Have you ever received vision training or eye exercises? _____ Dates of therapy _____

Who may we thank for referring you to our office? _____

I request that payment of authorized insurance benefits be made on my behalf to Dr. Ray M. Atcherson, O.D. for any services furnished me by that provider and authorize release of any medical information about me to my insurance carrier and agents necessary to determine these benefits or the benefits payable for related services. I understand that I will be financially responsible for any claims not paid by insurance.

I further understand that I will be responsible for a \$50 broken appointment fee, without providing at least 24 hours before canceling any appointment.

Signature _____ Date _____