

# WELCOME TO TOWN CENTER OPTOMETRY

Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last Middle First

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ M F SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

**Vision Insurance:** \_\_\_\_\_

Member's Name: \_\_\_\_\_ Member's I.D. Number: \_\_\_\_\_

**Medical Insurance:** \_\_\_\_\_

Member's Name: \_\_\_\_\_ Member's I.D. Number: \_\_\_\_\_

Medi-Cal: Yes No Medi-Cal I.D. Number: \_\_\_\_\_

Medicare: Yes No Medicare I.D. Number: \_\_\_\_\_

## How did you find out about our office?

Referral: Family Friend Provider Listing: Computer (on-line):  
Yellow Pages: Walk-In: Other: \_\_\_\_\_

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination.

I understand that I am financially responsible for all charges not paid by my insurance.

The basic eye exam provides a prescription for glasses only. For contact lens evaluation and fitting is provided upon request for an additional fee. Payment is due at the time services are rendered.

**Please note:** Checks returned unpaid by your financial institution are subject to a \$25.00 service charge or the maximum allowed by law.

Glasses and/or contact lenses that are not picked up within 60 days will be returned to stock and the deposit will be forfeited.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_