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 _____ Sex ___Male ___Female

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_____