Vision Care Clinic

Name: Mr., Mrs, or Ms., Miss._____ Today's Date: _____

Address: _____ PO Box_____ Phone: (_____) _____

City _____ State _____ Zip _____ Cell Phone # _____

Birth Date _____ Social Security # _____ Work # _____

Employer _____

Race: ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ White ☐ Other _____

E-mail Address: _____

Single _____ Married _____ Name of Parent/Guardian: _____

Spouse _____ Birth Date _____ Employer_____

Emergency Contact _____ Phone: (_____) _____

Name of Medical Doctor: _____ Last Eye Exam: _____

Please supply the following information regarding your Healthcare Insurance:

Insured's Name: _____Birth Date: _____ Employer: _____

Medical History

Do you have any allergies to Medication? No_____ Yes _____ If yes, explain: _____

_____

It is therefore clinic policy that **payment is due for professional services when provided**. A deposit of 50% is required for materials ordered and full balance due when dispensed. If other payment arrangements are necessary, do so in advance with our accounts manager. Medicare, Medicare supplements, Medicaid and other insurance claims are submitted by our office as a service to our patients. Thank you for allowing Vision Care Clinic, P.C. to provide care for your sight. If you have read, answered properly and understand the payment policy please sign:

X_____ Date: _____

Patient or Parent/Guardian