

WELCOME TO OUR OFFICE

FREMONT OPTOMETRIC GROUP

Name _____ Male Female Date: ___/___/___

Are you: Minor Married Divorced Widowed Single Separated

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____

Occupation: _____ Age: _____ Birthdate: _____

Your (or your parent's) Social Security Number: _____ Phone: Res. _____

Current Employer: _____ Phone: Bus. _____

Do you prefer to receive calls at: Home Work Either

Spouse's (or parent's) Name: _____

Spouse's (or parent's) Employer: _____ Phone: _____

If new to this office, whom may we thank for referring you? _____

In case of emergency, nearest relative not living with you:

Name: _____ Address: _____ Phone: _____

Insurance Information

Vision Insurance Carrier: _____ I.D. #: _____ Group/Employer: _____

Subscriber Name: _____ Relation to Patient: _____ Date of Birth: _____

2nd Vision Insurance Carrier: _____ I.D. #: _____ Group/Employer: _____

Subscriber Name: _____ Relation to Patient: _____ Date of Birth: _____

Medical Insurance Carrier: _____ I.D. #: _____ Group/Employer: _____

Subscriber Name: _____ Relation to Patient: _____ Date of Birth: _____

CONTACT LENS WEARERS

Please note that your Insurance may not cover the contact lens evaluation portion of the exam and you will be responsible for these charges.

TO ALL OUR VALUED PATIENTS: I certify that the information above is accurate. I agree to be responsible for the full payment of all charges and services rendered to myself and/or my dependents, regardless of insurance involvement. I understand office policy for all patient balances and/or coverages are to be paid at the time of order placement or services.

We make every effort to accommodate you by scheduling your appointment for the day and time you request. If you find that a reserved appointment is inconvenient for you, we ask that you give us 24 hour notice. We understand that emergencies can arise that may force you to cancel your appointment with less than 24 hour notice. However, we reserve the right to charge a \$25.00 Missed Appointment Fee for all non-emergency, short notice or no-show cancellations.

Patient Signature (or Parent of minor child)

Date