WELCOME TO OUR OFFICE

Purpose of visit: ___ Visual Examination
___ Contact Lens Fitting
___ Other _____

____ Male
YOUR full name_____ ____ Female
(Please print) (First) (Middle) (Last)

Please circle: Single Married Widowed Separated Divorced Other: _____

Ethnicity: White African American Native American Asian Hispanic Other: _____

Home address_____ Date of birth _____

City_____State_____Zip_____ **HOME** Phone_____ ☐

*[**Please note** that cell phone numbers and e-mail will only be* **CELL** Phone_____ ☐

used as a last resort for appointment changes /confirmation.] **e-mail:** _____

[PLEASE CHECK BOX "☐" OF THE PREFERRED PHONE NUMBER TO BE CALLED]

YOUR occupation_____ Employed by_____

Business address _____ **WORK** Phone_____ ☐

Who recommended you to our office? _____

. . . . . .

Spouse's Name _____ Occupation_____

Spouse employed by _____ Phone_____

. . . . . .

Payment is expected when services are rendered unless other arrangements are made in advance. (If you are ordering glasses or contact lenses, a one-half deposit is required to place the order, and the balance is due when they are dispensed.) Thank you.

Person responsible for account *** _____

Method of payment: ___Cash ___Check ___Visa ___MasterCard ___Discover ___Debit Card

***** INSURANCE INFORMATION *MUST* BE PRESENTED *BEFORE* YOUR EXAM OR WE *MAY NOT* BE ABLE TO UTILIZE YOUR INSURANCE FOR YOUR SERVICES.**

I hereby authorize Dr. Klaus and Dr. Stephenson to release any information and medical history necessary to process my claim. I agree that a photographic copy of this authorization shall be as valid as the original.

Signed _____ Date _____

<Please use the space below to enter the current date and initial anytime this information is reviewed and updated. Thank you.>

(If you have authorization for MEDICAID, SERVICES FOR THE BLIND, or other agencies to cover your charges, please sign the above authorization and present your card or paperwork to the receptionist **before your exam**.)