If you are the parent or guardian of the patient, please fill out and sign this form on their behalf

PATIENT INFORMATION (PLEASE PRINT) **Today's Date:** _____ / ____ /_____

Name: Last ____**First** _____________________________________**M.I.** ____

Address: ____

City: _______________________________State:_____________________________Zip Code: ______________

Home Phone: __________________________________Cell Phone: ____

SSN: _____ / ____ /_____ **DOB:** _____ / ____ /_____ **Age:** ____________ **Sex:** ☐ Male ☐ Female

Email Address: ____

Employer: ____**Occupation:** _____________________

Employer's Phone: ____Extension: _______________________

In Case of an Emergency Contact: _____________________________________ Phone: _________________________

Relationship: ____

How did you hear about us? (Circle One) Friend Family Doctor Facebook Google

VISION INSURANCE (PLEASE PRINT)

Vision Insurance: ____

Primary Insured's Name: ____ Primary Insured's SSN: _____ / ____ /_____

Primary Insured's DOB: _____ / ____ /_____

Relationship to Patient: ________________________________ ____

PERSON RESPONSIBLE FOR PAYMENT (IF SAME ABOVE LEAVE BLANK)

Name: Last_____________________________________ **First** _____________________________________ **M.I.** ____

Address: ____

City: _______________________________State:_____________________________Zip Code: _________

Home Phone: ______________________________Cell Phone: ___________________________________

SSN: ____________________**DOB:** _____ / ____ /_____ **Age:** ____________ **Sex:** ☐ Male ☐ Female

Email Address: ____

Employer: ____ **Occupation:** ___________________________