Welcome!

We are pleased to welcome you to our practice. We look forward to providing you with the best possible eye care today and in the future. Please take a moment to fill out this form as completely as you can.

Crystal Coast Optometry

PATIENT INFORMATION

Patient: ____
(Last) (First) (MI)

Salutations (Circle) Dr. Ms. Mrs. Mr. Other ________________

Date of Birth ________________________ Social Security #____________________________

Address ____ City________________________

State________________________ Zip _______________Email: ________________________

Telephone: Home___________________Work___________________Cell__________________

Employer_________________________________ Occupation_____________________________

How Referred (Circle) Insurance Yellow Pages Walk By Website Family/Friend________________

INSURANCE INFORMATION

Name of Insurance Subscriber ___________________________ SS#________________________

Name of Vision Insurance VSP EYEMED DavisVision MES Safeguard Other ___________________
(Circle)

Name of Major Medical Insurance:____

Policy Number: ________________________________ Group#__________________________

Assignment and Release

I, the undersigned, certify that I (or for my dependant) have insurance coverage with ________________
And assign to Crystal Coast Optometry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submission. No refunds are given on glasses or contacts already made by our laboratory, remake or exchanges only. All orders not dispensed within 30 days of notification will forfeit deposit unless prior arrangements are made.

Responsible Party Signature: __________________________________ Date_________________

Relationship: __________________________