OPTIC GALLERY
FAMILY EYE CARE

Patient Information

First Visit? Y / N

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ SS#: _____

Race: _____ Preferred Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Email: _____

Place of Employment/School: _____ Occupation: _____

How did you hear about us? _____

Insurance/Guarantor Information

Name:_____ Relationship: _____

Date of Birth: _____ SS#: _____

Employer: _____ Work phone: _____

Health Insurance Co.: _____ Policy #: _____

Vision Insurance Co.: _____ Policy #: _____

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Optic Gallery to do so. If applicable, I hereby authorize that payment by my insurance company be made directly to Optic Gallery for any services rendered to me. I also authorize Optic Gallery to release any information that is required to process a claim for services rendered.

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE COMPANY.

Signature (Patient or Guardian): _____ Date: _____

OFFICE USE
(Dr. Merhi only)

Refer to: _____

Testing today: VF/Refraction/Photos/Motility/Schirmer

Bill today's visit: Medical / Vision

RTC in: _____ days / weeks / months / years

For: Anterior / Posterior / CEE / CL / VF / Photos