ADULT PATIENT INFORMATION Male____Female____Other_____

Last Name________________________________First______________________________

Address____Apt.__________________

City____State____________________________Zip__________

Home Phone (_____)___________________________Birth Date: ______/______/______Age___________

Cell Phone (_____) __________________________E-Mail____

Married____Single_____

Spouse/Partner's ____
First Last

Your Occupation________________________________Place of Employment________________________________

Employment Address____Phone____________________________

City____State__________________Zip___________

Referred by (Indicate if more than one person referred you)

Name____

EMERGENCY INFORMATION

Name of nearest relative not living with you____

Relationship____Phone (______)___________________

Address_________________________________State____________City____________________Zip____________

I will be paying by: CASH______CHECK______CREDIT CARD______

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

I understand that in addition to the Examination fee there may be a separate Contact Lens Service fee.

This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, regardless of my insurance status, including reasonable attorney's fees and costs of collection in the event of default. I further understand that if payment becomes 60 days past due, delinquency charges of the annual rate of 18%, or the maximum allowable rate, will be due on delinquent amounts from the date that the payment was due.

Signature____Date__________________________________