PATIENT INFORMATION

Child____ Married___Single__

Patient's Last Name________________________First__________________ M__ F__

Address________________________________________Apt____________

City______________________________Zip__________________State______

Phone (_____)______________________________Birth Date ___/___/___ Age______

Occupation________________________Student__________________________

Place of Employment or Name of School

Name________________________________________

Address______________________________Phone(___)__________________

Patient Referred by: (We would like to thank them ,please give us their name)

Name__________________________Address__________________________

Name__________________________Address__________________________

PERSON RESPONSIBLE FOR THIS ACCOUNT

Mr.___Mrs.___Ms.___

Married___Single____

Relationship to Minor Patient__________________Spouse Name________________

Last Name___________________________First_________________________

Address________________________________________Apt______________

City______________________________Zip_______________State__________

Home Phone (___)_________________________Work Phone(___)_______________

Cell Phone (____)_________________________E-Mail______________________

Employer Name______________________Address_________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you________________________________

Relationship________________________Phone(___)_________________

This information is accurate and true to the best of my knowledge.

ACKNOWLEDMENT OF FINANCIAL RESPONSIBILITY

Payment for services due at the time services are rendered. We accept cash, check, Mastercard, Visa, AX.
I understand that in addition to the Examination fee there may be a separate Contact Lens Fitting fee.
INSURANCE WAIVER: Doctors at Century City Optometric Center do not participate in any medical insurance programs. Therefore, if you submit a claim to your insurance plan and it is denied as a non-contracted procedure code with your plan, or denied for any other reason, you are agreeing that your are financially responsible for all services.

Signature______________________________Date__________________