MINOR PATIENT INFORMATION

Male_____Female_____Other_____ Birth Date_____/_____/_____Age_____

Patient's Last Name_____First_____

Address_____Apt._____

City_____State_____Zip_____

Home Phone (_____)_____Cell Phone (_____)_____

School Name_____Grade_____

Patient referred by: Name_____

PERSON RESPONSIBLE FOR THIS ACCOIUNT

Last Name_____First Name_____

Relationship to Minor Patient_____

Married___Single____Spouse/Partner Name_____
Last First

Address_____Apt_____

City_____State_____Zip_____

Employer's Name_____Phone (____)_____

Address _____State_____Zip_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Relationship_____Phone_(____)_____

Address_____City_____State_____Zip_____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

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

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 statues, 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% of the maximum allowable rate, will be due.

I will be paying by: CASH_____CHECK_____CREDIT CARD_____

Signature_____Date_____