WELCOME TO OUR OFFICE

Today's date_____ Mr. Mrs. Ms. Dr. Sex: M / F

Last name _____ First name _____ MI _____

Address _____
No. Street City State Zip

Home phone_____ Work phone_____ Mobile phone_____

E-Mail _____ SSN_____-_____-_____ Date of birth _____

Employer / School _____ Occupation / Grade _____

Any special visual needs for hobbies/work _____

Family Physician _____ Family Dentist_____

Spouse's name _____

What is the reason for your visit today?
Routine examination
Received recall
Vision problems
Headaches/Eye Strain
Other_____

Billing Information

Person responsible _____ Relation _____

SSN _____-_____-_____ Employer _____

New patients: Whom may we thank for referring you to our office?_____

Please present any vision care <u>and</u> medical insurance cards to the front desk. We will bill your insurance company for any eligible services and materials. Please understand that we must have the correct insurance information at the time-of-service to bill properly and legally. Otherwise, the financial responsibility for services and materials will be yours.

Consent to Treatment, Authorization to Release Information, and Financial Responsibility

I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment, to my referring doctor or insurance company as necessary. I also understand that I am financially responsible for services and materials provided to me at the office of Bruce L. Manning, O.D. & Associates

Signature _____ Date _____