

WELCOME TO OUR OFFICE

PATIENT'S LEGAL NAME: _____ NICKNAME: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____ Ext: _____ Cell #: _____
Marital Status: _____ Sex: _____ Date of Birth: _____ Age: _____ E-mail Address: _____
SS #: _____ Employed By: _____ Phone #: _____
If patient is a minor, list both parents' names: Mother: _____ Father: _____
Occupation: Mother: _____ Work #: _____ Father: _____ Work #: _____
How did you hear about our practice? _____
Other family members that are seen in our office: _____
In case of an **emergency**, whom should we contact? (Someone **NOT** in your household)
Contact Name: _____ Relationship to Patient: _____ Phone Number: _____

FINANCIAL POLICY-ALL PATIENTS MUST READ:

1. All professional fees must be paid in full when services are rendered. We accept cash, checks and all major credit cards.
2. Glasses and contact lenses are custom-made items. Therefore we cannot give refunds once the order is made. When ordering any glasses or contact lens, the total must be paid in full.
3. All insurance plans must be pre-authorized before your appointment. We need at least 24 hours to determine eligibility. Discount plans are applied at the time of service. If you forget your discount card or don't know your information, your discount may be credited to your account for future use. No refunds shall be given.
4. There will be a \$35.00 fee for all returned checks. We do prosecute on all returned checks.

X _____
Signature of Patient or Parent (Guardian) _____ Date _____
Method of Payment: _____ Cash _____ Check _____ Credit Card

INSURANCE INFORMATION:

Are you *currently* covered under a **VISION** insurance plan YES or NO (If yes, present card to the receptionist)
Member's Name _____ Member's SS# _____
I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Cherokee Eye Group, Inc. all insurance benefits