

# Welcome to Newport Mesa Optometry

Thank you for giving us the opportunity to care for your eyes. We will do our best to make your visit here a pleasant experience. All information will be kept confidential.

Date: \_\_\_\_\_

Patient Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex M F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone # Home \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ E-mail \_\_\_\_\_

Employer \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse/Parent Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_

## INSURANCE INFORMATION

VISION \_\_\_\_\_

MEDICAL \_\_\_\_\_

SECONDARY \_\_\_\_\_

## WHOM MAY WE THANK FOR REFERRING YOU TO US?

PATIENT NAME \_\_\_\_\_

YELLOW PAGES INTERNET

INSURANCE OTHER

## PAYMENT & INSURANCE INFORMATION

Today's Services will be paid by: Cash [ ] Check\* [ ] Credit Card [ ]

Insured Name (if other than yourself) \_\_\_\_\_ Spouse [ ] Parent [ ]

Address \_\_\_\_\_ SS# (last four) \_\_\_\_\_ Birth Date \_\_\_\_\_

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature \_\_\_\_\_

## CONTACT INFORMATION

1. When calling regarding appointments/ test results, at what number and with whom may we leave a message? Name \_\_\_\_\_ Phone # \_\_\_\_\_ - \_\_\_\_\_

2. Emergency contact person (not living with you). Name \_\_\_\_\_

Phone # \_\_\_\_\_ - \_\_\_\_\_ Relationship \_\_\_\_\_

\*There is a \$25 fee for returned checks.