

WELCOME BACK TO OUR OFFICE

Name _____ Address _____ Date _____

Please check here if your name has changed since your last visit. Former Name _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Spouses's Name _____

Birth Date _____ Employer _____

E-mail Address _____ Social Security # _____

Would you prefer to be notified of appointments, your glasses or contacts by e-mail? Yes No

Since your last visit have you:

Had any eye surgery: Yes No Do you have Medicare? Yes No
Had any eye injury: Yes No Do you have Medicaid ? Yes No
Do you have supplemental Coverage?: Yes No Do you have BlueCross/BlueShield ? Yes No

There is no way for us to know positively whether we are a provider on your insurance plan. Please call your carrier to verify your coverage with Dr. Bryant, Allison or Dolan prior to your visit.

How will you be paying today?: Check Cash Credit Card

List any medical conditions you are being treated for: _____

List any medications you are taking (including over-the-counter medicines): _____

List any allergies to medicines (including over-the-counter medicines): _____

Payment is due when services are rendered.

Thank You

All information remains the same: _____ Patient Signature

Name Address Insurance Medications