



OPTOMETRY LONG BEACH

"The Clear Choice in Quality Vision Care"

WELCOME TO OUR OFFICE

PATIENT NAME: _____ Male / Female

BIRTHDATE: _____ SOCIAL SECURITY# _____

ADDRESS: _____

CITY: _____ ZIP: _____ PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ ADDRESS: _____

CITY: _____ ZIP: _____ PHONE: _____

MARITAL STATUS: MARRIED _____ SINGLE _____ WIDOWED _____ DIVORCED _____

SPOUSE: _____ EMPLOYER: _____

ADDRESS: _____ PHONE: _____

PARENT (IF MINOR) _____

IF NEW PATIENT, REFERRED BY: _____

FAMILY MEMBERS: _____

VISION INSURANCE COVERAGE: _____

SUBSCRIBER: _____ D.O.B. _____

MAJOR MEDICAL INSURANCE COMPANY: _____

This office is a provider for Vision **Service Plan (VSP)**, **Medical Eye Services of California (MESOC)**, and **Medicare**, and **other vision plans (PLEASE INQUIRE)**. Deductibles and any patient options not covered by your insurance plan will be expected to be paid in full at the time of your visit. With other forms of vision coverage, we will be happy to bill your insurance company without charge to you; however, **YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL.**

Payment is expected at the time of professional service; also a deposit of 50% is required prior to your material being ordered, remainder due upon receiving said materials.

I, the undersigned, have read the above and realize that all vision charges incurred by me, or my dependents for services rendered are my financial responsibility. All court fees, attorneys' fees, or other fees necessary to collect this account are payable by patient.

DATE _____ PATIENT SIGNATURE _____

Federal law requires that a written copy of the spectacle prescription be given to the patient. Contact lens prescription will be released only after a contact lens fitting has been completed.

***ALL PURCHASES ARE SUBJECT TO A CANCELLATION FEE.**