Welcome To Our Office
Waren Optometry

PLEASE ASSIST US BY PROVIDING THE FOLLOWING INFORMATION

First Middle Last

Name ____________________ SS# ______ - ______ - ______

Address ____________________ Apt# ______

City ____________________ State ______ Zip ______

Home Phone# ______________ Business Phone# ______________

Birth Date ______ Age ______ Sex: ☐ F ☐ M Cell Phone# ______

Date of Last Exam ______ Optometrist's Name ______

Job Title ______ Hobbies ______ Family Doctor ______

Who may we thank for referring you to us? ____________________

Insurance

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST

Primary Insurance Co. ______________ ID# ______________

Insured's Name ______________ Employer Group Name ______________

Member's Date of Birth ____________________

Secondary Insurance Co. ______________ ID# ______________

Insured's Name ______________ Employer Group Name ______________

I understand that by signing this consent form I am allowing my medical information to be released to my insurance company for such purposes as claims payment, provider review and quality assessment. I understand that I may revoke this consent in writing at any time. The revocation cannot apply to previously released information.

______________________ ______________

Signature of Patient or Responsible Party Date