Welcome to our office. Please fill in the blanks. Today's Date:____/____/____

Name: Last:	First:		M:	You go by:
Address:	City:		State:	Zip:
Phone: Home:	Work:	Sex: M, F	Birth date: / /	Age:
Occupation:	Employer:	City:		Soc. Sec. No.
Head of household/Guardian:	For students: School:		Grade:	Teacher:

Please circle how you found out about us:
phone book street sign vision insurance list relative friend worker other

Please circle the Vision Insurance you have if any:
State of Ohio Medicaid/ADC Medicare VSP/Vision Service Plan Vision Plus
Anthem Senior Advantage Blue Vision Blue Access Blue Preferred
Medical Mutual of Ohio Professional Risk Management

To acquaint you with our office policy:
We require payment for the eye exam or office visit as services are rendered. If glasses or contacts are ordered, we require at least one half down when the order is placed and the balance is due upon dispensing. We are providers with the insurance companies listed above and therefore accept payment from them. If you have a different insurance company, we ask that you pay us in full. We will then submit your insurance and any reimbursement would be sent to you. If you have any questions, the receptionist will be happy to answer them.

Please circle the method of payment you will be using. Cash, Check, MasterCard, Visa, Discover, Insurance.

I acknowledge that I have received a copy of *Notice of Privacy Practices* in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Please sign here that you understand the above:_____Thank You