The clear choice for expert vision care

617 South Main Street, Stillwater OK 74074
Office/ 405-372-7337 • Fax/ 405-372-7339 • web/ www.smitheyecare.com

PERSONAL INFORMATION

NAME:____ DATE: ____________________

ADDRESS: ______________________________________ CITY:____________________ ZIP: __________

EMPLOYER:____________________________________ OCCUPATION: _____________________________

HOME PHONE: (   ) ___________________________ WORK PHONE: (   ) _____________________

CELL PHONE: (   ) ____________________________ EMAIL ADDRESS: __________________________

BIRTH DATE: _______________________ AGE: _____ SSN OR OK DL NUMBER: ____________________

SEX: ❑ M ❑ F MARITAL STATUS: ❑ M ❑ S SPOUSES NAME: ___________________________

MAIDEN NAME:(if applicable)____

WHO WILL PAY THIS ACCOUNT TODAY?_____________ PHONE: (   ) ___________________________

METHOD OF PAYMENT: (Please check) ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ INSURANCE

IF 20 OR YOUNGER, PARENT'S NAME: ____

ADDRESS: ______________________________________ CITY:____________________ ZIP: __________

EMPLOYER:____________________________________ WORK PHONE:(   ) _______________________

INSURANCE INFORMATION

NAME OF MEDICAL INSURANCE: ____

NAME OF VISION PLAN: ____

SSN OR ID# OF INSURED: ____

GROUP OR POLICY NAME/NUMBER: ____

NAME OF INSURED OR COVERED EMPLOYEE: ____

PATIENT RELATIONSHIP TO INSURED: ____

INSURED'S ADDRESS: ____________________________ CITY:____________________ ZIP: __________

EMPLOYER:____________________________________ OCCUPATION: _____________________________

HOME PHONE: (   ) ___________________________ WORK PHONE: (   ) _____________________

BIRTH DATE: ________________________AGE: _____________ SEX: ❑ M ❑ F

WHAT ARE YOU INTERESTED IN? *Please check all that apply*

❑ GLASSES
❑ NO-LINE BIFOCALS
❑ SPORTS EYEWEAR
❑ SUNGLASSES
❑ CONTACTS FOR ASTIGMATISM
❑ RIGID CONTACTS
❑ BIFOCAL CONTACTS
❑ TINTED CONTACTS
❑ EXTENDED WEAR CONTACTS
❑ SOFT CONTACTS
❑ DISPOSABLE CONTACTS
❑ LASER VISION SURGERY
❑ NON-SURGICAL VISION CORRECTION
❑ OTHER ______________________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

❑ FRIEND OR RELATIVE (name) ____
❑ ANOTHER DOCTOR (name) ____
❑ STBJ.WATER DIRECTORY YP
❑ SWB YELLOW PAGES

I understand and agree that regardless of my Insurance status, I am ultimately responsible for the balance on my account I certify the information above is true and correct to the best of my knowledge. I understand my signature authorizes release of medical information for insurance submissions. I will notify Dr. Smith's office of any changes in the above Information.

____ ______________________________

SIGNATURE *DATE*

____ ______________________________

PARENT (If minor) *DATE*