## PLEASE PRINT CLEARLY

Appt. Time: _____ Walk-In Time: _____ Last Exam Date: _____ *Mark One:* ❑ New Patient ❑ Previous Patient

| **PATIENT** *(LAST, FIRST, MIDDLE INITIAL)* | DATE OF BIRTH | GENDER ❑ M ❑ F | SOCIAL SECURITY # |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |
| HOME PHONE | DAYTIME/CELL PHONE | EMPLOYER | |
| E-MAIL ADDRESS* | OCCUPATION | | |

**REQUESTS:** ❑ Glasses ❑ Contact Lenses ❑ Free Laser Vision Consultation ❑ Treatment of Dry Eyes / Eye Infection

***** *E-Mail address will be used to send you reminders for your annual exam and other eyecare information. We do not sell or rent your information.*

## FILL BELOW ONLY IF YOU HAVE VISION INSURANCE

**NAME OF VISION INSURANCE**

| **PRIMARY MEMBER** *(LAST, FIRST, MIDDLE INITIAL)* | DATE OF BIRTH | GENDER ❑ M ❑ F | SOCIAL SECURITY # |
|---|---|---|---|
| ADDRESS | *CITY* | *STATE* | *ZIP* |
| EMPLOYER | OCCUPATION | RELATION TO PATIENT | |
| HOME PHONE | DAYTIME PHONE | CELL PHONE | |

I have insurance coverage and authorize my carrier to pay and assign directly to Linden Optometry,A P.C. all benefits otherwise payable to me for the services described. I authorize Linden Optometry,A P.C. to release and obtain all information necessary to secure payment of said benefits. If my insurance fails to pay Linden Optometry,A P.C. in full, I agree to pay all unpaid balances. If litigation is instituted to collect any unpaid balance, I agree to also pay all costs, including reasonable attorney's fees incurred by Linden Optometry,A P.C. I have read, understood, and agreed to all terms and conditions stated on this agreement.

I understand that any description given is not a certification or guarantee of payment and is subject to its exclusions, limitations, and provisions outlined in the plan. Benefits will be determined at the time the claim is submitted.

I understand that the duration of the authorization is for the whole term of coverage. I agree that a photographic copy of this authorization is as valid as the original.

**SIGNATURE:** _____ **DATE:** _____

## HEALTH INSURANCE

In the event that a specialty test is necessary but is not covered by your vision insurance, please check which medical insurance applies to you.

[ ] PPO [ ] MEDICARE [ ] HMO [ ] KAISER [ ] OTHER _____