WELCOME TO OUR OFFICE

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

NICKNAME: _____ MR MRS MISS DR MARITAL STATUS: S M D W DP

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ ☐ SAME AS HOME EMAIL: _____

PATIENT DATE OF BIRTH: _____ PATIENT SS#: _____

PATIENT EMPLOYER/SCHOOL: _____ F.T. STUDENT: Y/N

PATIENT OCCUPATION / GRADE: _____

FAMILY PHYSICIAN (PCP): _____ DR.'S PH# _____

LAST MEDICAL EXAM: _____

FORMER EYECARE PROFESSIONAL: _____ LAST EXAM: _____

DO YOU WEAR: ☐ GLASSES ☐ SUNGLASSES ☐ CONTACT LENSES TYPE: _____

HAS ANY MEMBER OF YOUR FAMILY BEEN OUR PATIENT? _____

ARE YOU INTERESTED IN REFRACTIVE SURGERY FOR VISION CORRECTION? Y/N

WHO MAY WE THANK FOR REFERING YOU TO US? _____

FINANCIALLY RESPONSIBLE / INSURED: LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____ DOB: _____

RELATIONSHIP TO PATIENT: _____ LAST 4 SS#: _____

NAME OF VISION INSURANCE: _____ ID #: _____

NAME OF MEDICAL INSURANCE: _____ ID #: _____

PLEASE NOTE: WE BILL INSURANCE COMPANIES AS A COURTESY. INSURANCE AUTHORIZATIONS MAY NOT BE A GUARANTEE OF PAYMENT. I HERBY AUTHORIZE PAYMENT DIRECTLY TO DR. KRISTOPHER SKROMME FOR ANY INSURANCE BENEFITS, OTHERWISE PAYABLE TO ME, FOR SERVICES AND MATERIALS. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AT TIME OF SERVICE THAT ARE NOT COVERED BY MY INSURANCE.

LONG TIME AUTHORIZATION/FINANCIAL RESPONSIBILITY / "SIGNATURE ON FILE"

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____

(PLEASE TURN FORM OVER)