Lake Murray OPTOMETRIC

## Please fill out completely

MR.___MRS.___MS.____MISS ___DR___ Birthdate_____

First Name _____ Last Name _____

Driver's License# _____ SS# (needed for insurances) _____

Address _____City_____

State _____ Zip _____ Name of Spouse/Parent/Guardian_____

I give permission to Dr. Gonzalez and staff to contact me regarding issues of health and eye care by mail, phone or email as indicated.

Home Phone (____) _____ Yes / No

Cell Phone (____) _____ Text Yes / No

E-mail: _____Yes / No

Employer_____ Bus. Phone (____) _____

Occupation _____

Emergency Contact:_____ Phone_____

Vision Insurance Company and I.D. # _____Flex Account Y / N

Medical Insurance Company and I.D. # _____

Date of last eye exam _____ Medical Drs. Name _____

Whom may we thank for referring you _____

There will be a service charge on returned checks, missed appointments w/out notice and late payment
I UNDERSTAND THAT ALL CHARGES ARE DUE ON THE DAY SERVICES ARE RENDERED.
I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANYCHARGES MY INSURANCE DOES NOT PAY FOR.

**I acknowledge that I am aware of The Privacy Act as stated by HIPAA at the office of Lake Murray Optometric Center**

**Patient's Signature _____Date_____**