OPTIMA OPTOMETRY
WELCOME TO OUR OFFICE
In order to best serve you, please complete this registration form.

LAST NAME: ____
FIRST NAME:____Middle Initial: ________
How would you like us to address you? Mr___ Ms___ Mrs___ Dr___ By first name ___ Other _______

ADDRESS: ____
CITY: _________________________________STATE: ____________________ ZIPCODE:______
HOME PHONE: _________________________DAYTIME PHONE: ________________________
CELL PHONE: __________________________
EMAIL ADDRESS: ____

SEX: Male ______ Female ______
DATE OF BIRTH: MONTH _______DAY ______ YEAR ______________
SOCIAL SECURITY: __________-_________-__________

Please check one:
MARITAL STATUS:
Single ___ Married ___ Divorced ___ Separated ___ Other ___

EMPLOYMENT STATUS:
Employed Full time___ Not Employed___ Retired___ Student___
Employer: ____
Occupation: ____

Who referred you to this office:
Another patient___ Professional___ Advertisement___ Other__________________________________

IF CHILDREN UNDER 18 YEARS OF AGE, PLEASE PROVIDE:
NAME OF PARENT OR GUARDIAN: ___________________________Phone:______________
STUDENT STATUS: FULL TIME ____ PART TIME ____

WHAT VISION INSURACE DO YOU HAVE?
VSP ___ EYEMED ___ DAVIS VISION ___ MEDICAL EYE SERVICES ___
GREATWEST ___ SAFEGUARD ___ OTHER____

WHAT MEDICAL INSURANCE DO YOU HAVE?
NAME OF MEDICAL INSURANCE:____
PLEASE CIRCLE ONE: PPO HMO OTHER

PLEASE, GIVE TO RECEPTION YOUR MEDICAL INSURANCE CARD TO MAKE A COPY & KEEP ON FILE.

I AGREE TO PAY FOR MY EYE EXAMINATION, OFFICE VISITS & MATERIALS IN CASE MY INSURANCE DOES NOT COVER.
Signature:____

I HAVE READ THE ENCLOSED PRIVACY ACT.
Signature: ____