

New Patient Welcome Form

Large Print

Type or write your answers. Print, sign where indicated, and bring to your visit.

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**

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**

Other

**IF CHILDREN UNDER 18 YEARS OF AGE,
PLEASE PROVIDE:**

NAME OF PARENT OR GUARDIAN

Phone

STUDENT STATUS FULL TIME / PART TIME

WHAT VISION INSURANCE 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 (print and sign)

I HAVE READ THE ENCLOSED PRIVACY ACT.

Signature (print and sign)
