WELCOME TO MOUNTAIN VIEW EYE ASSOCIATES

NAME_____**DATE OF BIRTH**_____**AGE**_____
FIRST MI LAST

ADDRESS_____**CITY**_____**STATE**___**ZIP**_____**SSN**___-___-____

PHONE_____**WORK PHONE**_____**CELL PHONE**_____

EMERGENCY CONTACT _____**PHONE** _____

PREFERRED WAY OF CONTACT: **HOME PHONE** **WORK PHONE** **CELL PHONE** **TEXT**

PLACE OF EMPLOYMENT_____**OCCUPATION**_____

DATE OF LAST EXAM AND WHERE_____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

EMAIL ADDRESS_____
(Necessary for Appt. confirmation. notifying of glasses or contacts). Will not be given out to 3rd party

MARRIED____**SINGLE**_____**DIVORCED**_____**WIDOWED**_____

When two or more insurances are available, the one used first is your own, with other insurances used second. If you are a dependent of those with insurance the insurance holder with the earliest birth date in the calendar year is used first.

PAYMENT FOR SERVICES IS DUE AT THE TIME OF SERVICE. A 50% DEPOSIT IS REQUIRED ON ALL MATERIALS ORDERED. BALANCES ARE DUE AT THE TIME MATERIALS ARE PICKED UP.

Mountain View Eye Associate provides additional specialized testing, which may at times be billed to your regular "major medical" health insurance. In the event any of these tests are necessary, please authorize payment directly to Mountain View Eye Associates by providing your signature below. Our insurance department will handle all necessary claims. If your insurance does not pay or it is out of network you will be responsible to make payment to us.

_____ _____
SIGNATURE **DATE**

PLEASE RETURN THIS FORM TO THE FRONT DESK AND HAVE YOUR HEALTH AND VISION INSURANCE CARDS READY TO COPY.