

Welcome to All About Eyes Optometry

Please take a moment to complete the following information.

If you have any questions, please do not hesitate to ask.

Please print clearly.

Mr. Mrs. Miss Ms.

Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

(____) (____) (____) / /
Home Phone Day Phone Mobile Phone Birthdate Social Security Number

Email address CA Driver's License #

If married, name of spouse If child, parent's name

Patient Status: Single Married Divorced Widowed

How were you referred to our office? Name of Responsible Party (if different than patient)

Method of payment for today's services: Cash Debit Visa/Mastercard Check Insurance

Primary Insurance Information

Please give your card to the receptionist.

Primary member name Birthdate Patient Relationship to Insured (Self, Spouse, Child, Other)

Secondary Insurance Information

Please give your card to the receptionist.

Primary member name Birthdate Patient Relationship to Insured (Self, Spouse, Child, Other)

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Payment from my insurance is to be paid directly to All About Eyes Optometry.

There are no refunds for custom orders or shipping and handling fees. Returnable items will have a 20% restocking fee/full credit on exchange. Accounts 30 days old are subject to finance charge of \$5 per month (or the greater of 18% per annum) and 90 days old to collection fees. There will be a service charge on all returned checks.

Signature of Responsible Party Date