Family Vision Associates, P.A.

Welcome to Our Office

For Faster service, please complete the following form prior to arriving at our office

Patient Name _____

Spouses Name _____

If a Child, Responsible Parent's Name _____

Street Address_____

City_____ State_____ Zip Code _____

Cell Phone _____ Home Ph _____ Work Ph _____

Preferred Contact: Cellphone-Text/Voice Message, Work, Home Phone, or Email

E-mail Address_____

Birth Date _____ M or F _____ SSN _____

Employer _____ Occupation _____

Spouse Employer _____ Occupation _____

Health Insurance Carrier _____ Policy # _____

Medicare _____ Policy # _____

How did you find out about our office? _____

I authorize the release of any medical information necessary to provide the most complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at time of services rendered.

Signature _____ Date _____

Form 2015