ESCONDIDO *OPTOMETRIX*
FAMILY OPTOMETRY
Garrick Sit, OD Lianne Mizoguchi, OD

WELCOME TO OUR OFFICE! Today's Date _________________

Last Name _______________________________________ First Name _______________________________ MI __________

+ Mr + Mrs + Miss + Ms + Dr + Other ________

Birthday ___________________________ SS# ______________________ Spouse _______________________

Address: Street____ City__________________________ Zip________

Home Phone: _________________ Cell Phone: _________________ Email Address __________________________

Work Phone: ____________________ Employer: _________________________Occupation ____________________

Drivers License # __________________________________ State ________ Expiration _______________________

Head of Household (financially responsible for bill) ____

Their Birthday ____________ SS#___________________ Spouse______________________________________

Address ____ City ___________________________ Zip _________

Who may we THANK for REFERRING you to our office? ____

Please check the preferred method of payment + Cash + Check + Visa/MasterCard + American Express

Please check if one applies to you: + Medicare + Vision Insurance ____________ + Other Insurance ___________

If insurance, who is the insured member? ________________________

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services and materials.

I understand that payment is expected at the time of visit and/or when materials are ordered; including any insurance deductibles or extras.

Any materials ordered that are left over 30 days, or cancelled will be returned or discarded and no refunds will be available.

A pair of glasses will be provided IN EXCHANGE for contact lenses if deemed unsuccessful. Fitting fees will not be credited.

Interest will be charged on any account over 30 days and is the responsibility of the patient. (1.67% monthly) Checks returned for any reason are subject to a $20.00 service charge. All collection costs are the patient's responsibility.

I have read all the information of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge.

SIGNATURE ____ DATE _______________________
(if patient is a minor, PARENT SIGNATURE

Thank You