

ESCONDIDO OPTOMETRIX
FAMILY OPTOMETRY
Garrick Sit, OD

WELCOME TO OUR OFFICE!

Today's Date _____

Last Name _____ First Name _____ MI _____

+ Mr + Mrs + Miss + Ms + Dr + Other _____ Nickname _____

Birthday _____ SS# _____ Spouse _____

Address: Street _____ City _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email Address _____

Work Phone: _____ Employer: _____ Occupation _____

Sign up for our Patient Portal? (receive receipts and prescriptions electronically): + Yes + No

Communication Preference: + Text Message + Email + Telephone

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 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