**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 _____

Communication Preference: ☐ Text Message ☐ Email ☐ Telephone

Do you consent to have prescriptions or receipts be sent electronically? ☐ Yes ☐ No

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: ☐ Self Pay ☐ 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 <u>over 30 days</u>, or cancelled will be returned or discarded and <u>no refunds</u> will be available. Fitting fees will not be credited.

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