



ACCURATE VISION CLINIC

CARE AS PERSONAL AS IT IS EFFECTIVE

Today's Date: _____

Patient Information Form

PATIENT'S INFORMATION

Name: _____ Social Security #: _____ Date of Birth: _____

Hm. Phone: _____ Wk. Phone: _____

Cell Phone: _____ E-mail Address: _____

Home Address: _____ City: _____ Zip Code: _____

Spouse's Name: _____ Wk. Phone: _____

Nearest relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Landlord: _____ Phone: _____

Whom may we contact in the case of an emergency? _____ Phone: _____

Whom may we thank for referring you to us? _____ Phone: _____

BILLING INFORMATION

Who is responsible for this bill? _____

I will be paying today by: Cash Check Credit Card:

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date: _____

Parent (if minor): _____ Date: _____

STANDARD OF CARE ANNOUNCEMENT

Please Read Carefully Before Signing

I understand that Accurate Vision Clinic will conduct a digital retinal scan for eye disease detection, which will cost \$29.00 and is not insurance or vision plan covered benefit. I will be responsible for payment for this retinal scan at the completion of my vision examination.

Signature of Patient: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____

Initials: _____ Date: _____