Welcome to Our Office.
Please Help Us By Supplying The Following Information:

NAME: _____ Date of Birth: _____ AGE: _____

By What Name Do You Prefer to be Called? _____ SOCIAL Security #: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Widowed

Address: _____

_____ Zip Code: _____

Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Occupation: _____

Parent's or Spouse's Name: _____

Referred By (another patient, insurance plan, etc): _____

Address: _____

General Physician's Name: _____

Address: _____

What is Your Preferred Method of Payment: ☐cash ☐check ☐visa ☐mastercard

INSURANCE COVERAGE: We are a provider for a number of managed vision care plans. If you have one of these plans, we will gladly accept assignment. If you do not, we will gladly fill out any forms you would need for reimbursement.

Vision Care Insurance Plan: _____ ID #: _____
Patient's Relationship to Insured: ☐ self ☐ spouse/domestic partner ☐ child

Primary HEALTH INSURANCE Plan: _____ ID #: _____
Patient's Relationship to Insured: ☐ self ☐ spouse/domestic partner ☐ child

PLEASE READ, SIGN, AND DATE:

For Patients with Managed Care or Voucher Plans: I hereby assign my insurance benefits to be paid directly to Dr Serhrouchni. I understand that I will be responsible for any deductibles or co-payments. If my insurance coverage is denied, I will be responsible for all usual and customary fees. I also understand that my vision plan may not cover all examinations, tests, and treatments that Dr. Serhrouchni feel are necessary or advisable. If I decline these items or choose to go elsewhere through other coverage, I will not hold Dr. Serhrouchni liable for any damages due to my delay in seeking treatment.
For All Patients: If my account must be turned over for collection, I will also be responsible for all interest and collection fees.

Signed: _____ Date: _____