



# Welcome to Family Optometry Center

Miguel Delgado, O.D.

Christopher J. Feahr, O.D.

Ian J. Middleton, O.D.

## ***Patient Information***

Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Birthday: \_\_\_\_\_

SSN: \_\_\_\_\_

e-mail: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_

## ***Personal Information***

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children still at home (and ages): \_\_\_\_\_

## ***Insurance Information***

*Please provide all vision and/or medical insurance **prior** to your eye exam*

Vision Insurance Company: \_\_\_\_\_ Member SSN \_\_\_\_\_

Medical Insurance (PPO/HMO/Etc): \_\_\_\_\_ ID#: \_\_\_\_\_

***Payment is expected at the time services are rendered and/or eyewear is ordered.***

***You are responsible for all charges not covered by insurance.***

By signing below I acknowledge that I have received a copy of Family Optometry Center's Notice of Privacy Policy, I also understand and agree to the office financial policies.

Signature: \_\_\_\_\_ /date \_\_\_\_\_

### **Family Optometry Center accepts the following payments:**

Cash   Check   VISA   MasterCard   ATM/Debit   AMEX   Discover   Care Credit

Whom may we thank for referring you? \_\_\_\_\_

**\*\*\*Turn over to complete medical history\*\*\***