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winking bee OPTOMETRY

Welcome Form

Patient Name:		Title: (circle) Mr. Mrs. Ms. Dr.
Birthdate:	Age:	Nickname:
Gender: Male / Female	Primary Language	SSN:
Address:		
City:		State, Zip
Home Phone:		Work Phone:
Cell phone:		Communication Preference: Home Work Cell Email Text
Email:		

I authorize Winking Bee Optometry to use my e-mail address for practice communications such as appointment confirmations and notification of orders.
I can opt out of email communication at any time. Winking Bee Optometry does not share, distribute, or sell any patient information.

Occupation:	How did you find Winking Bee? Whom may we thank for referring you?
Employer:	

Primary Insurance

Subscriber (if self, write self)	SSN:
Relationship to Patient:	Birthdate:
Home phone *or* Cell phone:	Email
Vision insurance: *(Circle)* VSP Eyemed Other Name of other insurance:	Medical Insurance: *(circle)* PPO or HMO Name of Insurance:

Secondary Insurance

Subscriber:	SSN:
Relationship to Patient:	Birthdate:
Home phone *or* Cell phone:	Email
Vision insurance: *(Circle)* VSP Eyemed Other Name of other insurance:	Medical Insurance: *(circle)* PPO or HMO Name of Insurance:

Emergency Contact

Name:	Relationship:
Primary phone:	Email:

Payment Terms: We accept most major credit cards and cash. We are happy to assist you in filing your insurance claim.
If your Insurance does not pay the anticipated amount, or pays you directly, we ask that you agree to pay the balance.
Office Policy is that full payment is due at the time services are rendered.
I have read and agree to all provisions in full of the payment terms and office policy:

_____	_____	_____	_____
Signature of Patient/Guardian	Print Name	Relationship	Date