DR. GLENN D. GREEN

Optometric Physician

WELCOME TO OUR OFFICE

DATE:_____

PATIENT'S NAME: Mr Mrs Miss Ms Dr_____
(circle one) LAST FIRST MI

HOW DO YOU WISH TO BE ADDRESSED?_____

PATIENT'S DATE OF BIRTH: _____/_____/_____ SEX: M F

PATIENT'S ADDRESS:_____
STREET

_____ _____ _____
CITY STATE ZIP

PATIENT'S HOME PHONE:_____ CELL PHONE_____ WORK PHONE_____

PATIENT'S SOCIAL SECURITY NUMBER:_____

PATIENT'S OCCUPATION:_____
(IF STUDENT, LIST GRADE, SCHOOL AND TEACHER)

PATIENT'S EMPLOYER:_____

SPOUSE NAME:_____RESPONSIBLE PARTY:_____
(FOR CHILDREN UNDER 18)

I CURRENTLY WEAR ❑ GLASSES ❑ CONTACTS. WHO PRESCRIBED THEM?_____

WHOM MAY WE THANK FOR REFERRING YOU TO US?_____

We gladly accept the following insurance plans (please check if applicable):

❑Regence or BC/BS ❑Medicare ❑Medicare supplement_____ ❑Group Health
❑Community Health Plan ❑First Choice ❑DSHS ❑Premera ❒ Tricare

Name of Subscriber_____ Subscriber I.D. No._____

If your insurance is not listed above, we would ask that payment be made when services are rendered. We will provide an insurance bill that you can send in to your insurance company for reimbursement.

_____

I understand that I am responsible for payment of any charges not covered by my insurance. I authorize payment of health care benefits to this clinic. I also authorize release of any medical records necessary to process any claims.

X_____
patient / guardian signature

Full payment for services, glasses and contacts is due when received. THANK YOU.