

Welcome To Our Office

Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms.

First Name _____ MI _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address _____ Spouse or Parent(s) Name _____ Person Responsible for Account (Must sign below) _____

Employer _____ Name Of Medical Doctor _____ Location Of Medical Doctor _____

Primary Insurance Information

Secondary Insurance Information

Company name _____

Company name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

M Insured's

M Insured's

F Name

F Name

Insured's ID Number _____

Insured's ID Number _____

Group Number _____

Group Number _____

Insured's Date of Birth _____

Insured's Date of Birth _____

Patient Relationship to Insured

Self Spouse Child Other

Patient Relationship to Insured

Self Spouse Child Other

Tell Us About Yourself So That We Can Better Meet Your Eyecare Needs

Do you have a backup pair of glasses? yes no

Does night time glare bother you? yes no

Do you currently wear contact lenses? yes no

Does sunlight bother you? yes no

Would you be interested in a trial of the latest in contact lens designs? yes no

Do you work on a computer? yes no

Would you like thinner, lighter lenses? yes no

Please list your hobbies: _____

Please list other members of your household: _____

How were you referred to our office? _____

Please Read and Sign:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to JA WILLIAMS PLLC. I understand that Medicare will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____

Date _____