

S.S. NUMBER: _____ TODAY'S DATE: _____

FIRST NAME: _____ MIDDLE: _____ LAST: _____

SEX: M / F CHILD'S DATE OF BIRTH (MM/DD/YY): ____/____/____

ADDRESS: _____

CITY: _____ STATE: ____ ZIP CODE: _____

PRIMARY ADULT RESPONSIBLE FOR PATIENT: _____

RELATIONSHIP TO PATIENT: ___ MOTHER ___ FATHER ___ GRANDPARENT ___ OTHER

SECONDARY ADULT RESPONSIBLE FOR PATIENT: _____

RELATIONSHIP TO PATIENT: ___ MOTHER ___ FATHER ___ GRANDPARENT ___ OTHER

NAMES OF SIBLINGS (BROTHERS/SISTERS): _____

ANY SIBLINGS HAVE VISION DIFFICULTIES OR REQUIRE VISION CORRECTION? YES/NO

PATIENT'S HOME PHONE: _____ PRIMARY ADULT'S PHONE: _____

EMAIL:* _____ SECONDARY ADULT'S PHONE: _____

**By providing us your email address, you agree to receive practice news, appointment reminders, and special offers directly from Vincett Eye Care Associates. Your email address will never be shared or sold to a third party.*

SCHOOL NAME: _____ GRADE: _____ SCHOOL DISTRICT: _____

Does your child have any school or learning problems? Yes or No

If yes, what subjects? _____

Please send a report to: ___ School nurse ___ Teacher ___ Primary Care Physician ___ Pediatrician

Name: _____ Address: _____

Please sign to authorize: _____

HOW DID YOU HEAR ABOUT US? (Please check all that apply.)

___ Referral Name of person who referred you: _____

___ Insurance provider list

___ Our Web site ___ Facebook ___ Search engine If so, which one? _____

___ Print advertisement Which paper or magazine? _____

___ Office signage

___ Direct mail letter or postcard

___ Newsletter

___ Other (please specify) _____

VISION INSURANCE: _____ I.D. NUMBER: _____

GROUP #: _____ POLICY HOLDER'S NAME: _____

CUSTOMER SERVICE PHONE NUMBER: _____

We request an initial deposit of 50% of the patient's balance at the time of examination and the balance due when the services are completed. If you pay your balance in full by cash or check on your initial visit, you will receive a 5% discount. (not applicable with insurances or other discounts)