WELCOME TO NEW VISION CENTER

2930 S First St. Suite 700 Garland, TX 75041

Patient Information

Name: _____ D.O.B_____/_____/_____ Sex: Male / Female

Address: _____ City: _____ State: ____ Zip Code_____

Phone Number: _____ Email: _____

Height: _____ Weight: _____ Race: _____ Language:_____

Pharmacy *(Please Mark One)*

CVS____ Walgreens ____ Walmart____ Other_____ Street Name:

_____

Insurance Information

Insurance Name: _____ Insured's Name: _____

Relationship to Patient: _____ S.S #: _____-_____-_____ D.O.B _____/_____/_____

Insurance authorization: I hereby authorize the physician(s) indicated to furnish information to the insurance carriers concerning my eye's problems and/or treatments and I hereby irrevocably assign to the physicians all payments for services rendered to myself or to my dependents. I understand that I am financially responsible for all charges if not covered by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original. **Initials:** _____

Your reasons for visiting our office today (Please check all the applies)

Routine Eye Exam ___ Medical Visit ___ Other: _____

Do you wear contact lenses? ____ Type: _____

List any Medical or Ocular conditions that apply to you: _____

What specific problems do you have with your eyes or vision: _____

Medications taken presently: _____

Any drug allergies? _____

Smoke? ___ Yes ___ No Are you Pregnant? _____

Additional Exams (Optional)

Dilation- $20 ___ Visual Field- $20 ___ Topographer-$25 ___

I understand I am legally responsible for payments of all charges; no price adjustments or promotions can be combined while using my insurance. Co-payments or non-covered items need to be paid at the time services are rendered. If glasses are not picked up after 6 months, they will be donated. No refunds are available once materials were cut and made. Contact lens will have a 25% re-stocking fee. We are not responsible for any frame breakage or damage, when using your own frame. I have read the foregoing, and I am the patient, parent or guardian, and authorize this agreement and accept its terms.

Signature: ____ **Date:** ____________________