Last Name ________________________________ ***DOB*** ________________________________

First Name ________________________________ ***M Initial*** ____________________________

Street Address ____

City ______________________________________ ***State*** ________ ***Zip*** ___________________

Social Security Number _______________________

Person responsible for payment ____

Please list all methods where we can call, leave a message, or contact you electronically

Home ____________________________ ***Work*** ________________________________

Cell ______________________________ ***Email*** _______________________________

<u>Vision Insurance</u>: ________________________________

ID# _________________________ ***Group#*** ______________________

Primary member: _________________________________ ***Member DOB:*** _____________

Relationship: ________________________ ***Employer:*** ____________________________

<u>Medical Insurance</u>: ____

ID# _________________________ ***Group#*** _______________________

Primary member: ________________________________ ***Member DOB:*** _____________

Relationship: ________________________ ***Employer:*** ____________________________

Please list names of family members or individuals involved in your health care with whom we may discuss your care

____ ____

____ ____

Consent to treat: *I hereby give my consent to Dr. William E. Conn to provide eye care services to myself and/or family members. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account and for any professional services and materials provided by Dr. Conn.*

____ ____________________________________

Patient or guardian signature ***Date***

Form 12/2016