



**Patient Information**

First Visit? Y / N

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Place of Employment/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Insurance/Guarantor Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ Work phone: \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

Vision Insurance Co.: \_\_\_\_\_ Policy #: \_\_\_\_\_

In the event that it becomes necessary for us to release your records to or request your records from another healthcare professional, I authorize Optic Gallery to do so. If applicable, I hereby authorize that payment by my insurance company be made directly to Optic Gallery for any services rendered to me. I also authorize Optic Gallery to release any information that is required to process a claim for services rendered.

**I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE COMPANY.**

**Signature (Patient or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_**

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OFFICE USE  
(Dr. Merhi only)

Refer to: \_\_\_\_\_

Testing today: VF/Refraction/Photos/Motility/Schirmer

Bill today's visit: Medical / Vision

RTC in: \_\_\_\_\_ days / weeks / months / years

For: Anterior / Posterior / CEE / CL / VF / Photos