STANISLAUS OPTOMETRIC CENTER, INC. ***PLEASE PRINT AND* * * FILL OUT COMPLETELY * ***

4028 Dale Road, Suite102♦Modesto, California 95356♦(209) 527-2020♦Fax (209) 527-5079♦www.stanopto.com

PATIENT'S NAME_____ DATE OF BIRTH____/____/_____ SEX ___M / F___
Last First Middle

ADDRESS_____ HOME PHONE #_____ CELL #_____
Number & Street City State Zip

( ) STUDENT - Part / Full Time ( ) CHILD ( ) SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED

PATIENT'S SOC. SEC. # _____-_____-_____ **PATIENT'S EMAIL ADDRESS** _____

RESPONSIBLE PARTY'S NAME_____ **SOC. SEC. #** _____-_____-_____ **CDL#**_____
(If Different) (If Different)

RESPONSIBLE PARTY'S EMPLOYER NAME and ADDRESS_____ WORK #_____

HOW DID YOU HEAR ABOUT US? _____ PATIENT'S PRIMARY PHYSICIAN _____

OTHER RESPONSIBLE PARTY'S NAME_____ **SOC. SEC. #** _____-_____-_____ **CDL #**_____

OTHER RESPONSIBLE PARTY'S EMPLOYER NAME AND ADDRESS_____

RELATIVE OR FRIEND *NOT LIVING WITH YOU* WHOM WE CAN CONTACT IN THE EVENT OF AN EMERGENCY:

NAME_____ ADDRESS_____

HOME PHONE_____ WORK PHONE _____ RELATIONSHIP_____

PLEASE LIST THE OTHER FAMILY MEMBERS LIVING WITH YOU:

Name	Age	Relationship To Patient

Any occupational tasks, hobbies, or sports that may require a special prescription or protective eyewear? _____

Are you interested in: Laser Surgery_____ Contact Lenses_____ CRT (contacts overnight to correct your vision for the next day) _____

FINANCIAL INFORMATION:

PRIMARY **VISION** INSURANCE_____ SUBSCRIBER'S NAME _____
Last First

SECONDARY **VISION** INSURANCE_____ SUBSCRIBER'S NAME _____

PRIMARY **MEDICAL** INSURANCE _____ SUBSCRIBER'S NAME _____

GROUP/CERTIFICATE # _____ ID # _____ EFFECTIVE DATE _____

SECONDARY **MEDICAL** INSURANCE _____ SUBSCRIBER'S NAME _____

GROUP/CERTIFICATE # _____ID# _____ EFFECTIVE DATE_____

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT: I authorize treatment for the person named above and agree, irrevocably, whether signing as an agent or as a patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of insurance benefits directly to the provider named above, and any assisting physicians for services rendered. If my insurance policy prohibits that payments be made only in my name, I instruct and authorize the insurance company to mail the check made out in my name directly to the provider at the office address on the claim. As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit-reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We gladly Accept Assignment for your insurance benefits but we will NOT enter into a dispute with your insurance company. **Therefore, you will be required to pay for any non-dispensed eyeglasses and contact lenses or insurance claims outstanding past 60 DAYS from the original date of service using your credit card we have here on file. There is a $40.00 fee for any missed appointments without a 24-hour prior notification, a $25.00 fee for all returned checks, and a $5.00 minimum monthly billing fee.** In addition to cash or checks, Visa, MasterCard, American Express and Discover cards are accepted.

RELEASE OF INFORMATION: The provider may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the provider or to the patient, family member, or the employer of the patient or the family member for all or part of the provider's charge, including but not limited to, medical service companies, workman's compensation carriers, welfare funds, the patient's employer, and the patient's Primary Physician or other doctor as deemed appropriate. I further authorize my employer to release employment information to the provider or the provider's agents.

Rev. 02/07

_____ _____
Signature **Date**