
Welcome to Our Office!

We're glad you've chosen NorthWest Eye Center to provide your eye care needs.
Kindly fill in this form completely on both sides.

Patient's Name: _____

If patient is a minor, guardian's name: _____

Address: _____ City: _____ Zip: _____

Does your health insurance plan provide for routine vision care? Y N
(Most health insurance plans pay for medically-oriented visits.)

Health Insurance Carrier: _____ ID: _____

Insured's Name: _____ Insured's Date of Birth ____/____/____

Patient's SS# ____-____-____ Insured's SS# ____-____-____

(Please give copies of any Medicare, Medicaid, or Insurance cards to the receptionist.)

If you wear contact lenses and might like to order them online, please give us your email address so we can register you to re-order from our website: _____

How did you hear about our office? _____

One of our practice goals is to provide your professional care and materials at the lowest cost possible. To allow us to do that, we require that all exam, fitting, and treatment fees and any insurance co-pays be paid at the time of the exam. *If you are not prepared to pay these fees today, please inform the receptionist before your examination or treatment.*

In addition, eyeglasses and special contact lens orders may be ordered with a minimum of 50% deposit, with the balance payable upon pickup.
Disposable contact lenses require no deposit, but must be paid for at the time they are dispensed.

*I acknowledge that I have read and agree to the financial terms stated above, and I authorize release of any medical information necessary to provide the most beneficial and complete visual examination and payment for any services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance.*

Signature: _____ Date: _____