Dr. Franklin Levin, Optometrist
Eyecare You Can Trust

WELCOME TO OUR OFFICE. WE'RE GLAD YOU'RE HERE.
PLEASE COMPLETE THIS FORM FOR YOUR RECORDS.

Date_____ This ❑ is ❑ is not my first visit.

My name is ❑ Mrs. ❑ Mr.
❑ Miss ❑ Dr. _____

The name I wished to be called is: _____

Address: _____

Email Address: _____

My phone numbers are: Home _____ Office _____ Cell _____

My birthdate is_____ / ____ / _____ My age is _____ My social security number is _____

I am employed by _____ as _____

STUDENTS

School _____ Grade _____ Teacher _____

Mothers full name _____ Home phone _____ Office phone _____

Mothers address _____

Fathers full name_____ Home phone _____ Office phone _____

Fathers address _____

How did you know about us? Did someone tell you? _____

Where did you find our telephone number? ❑ Insurance list ❑ White Pages
❑ Yellow Pages ❑ Our web site ❑ Other _____

My last eye exam was _____

Have you had any injuries or operations to your eyes? _____

Are you allergic to any medications? _____

My Primary Care Physician is Dr. _____

Please list all medications you are taking: _____

Do you have an employee sponsored Medical Flexible Spending Program? ❑ Yes ❑ No

I now wear: ❑ No vision correction ❑ Contact lenses ❑ Soft ❑ Hard ❑ Glasses for: ❑ Full time ❑ Far ❑ Reading

For contact lens wearers: I wear daily ❑ or extended wear(overnight) ❑. The brand of solution I use is _____ .

I want my eyes examined today because: _____

_____

_____

I plan to take care of my account today by:

❑ Cash ❑ Check ❑ VISA ❑ Mastercard ❑ American Express ❑ Discover

Please complete other side also.

(CONFIDENTIAL)

PLEASE COMPLETE THIS SIDE ALSO.

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ NO ❑ YES IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Franklin Levin to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Franklin Levin insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (Or parent if a minor) DATE

Reviewed with patient by _____ Date _____

(CONFIDENTIAL)