



New Patient Intake Packet

Patient Information

Full Legal Name

Preferred Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact

Insurance Information

Primary Insurance

Member ID

Group Number

Policy Holder Name

Secondary Insurance

Medical History

Primary Care Physician

Medications

Allergies

Medical Conditions

Surgeries / Hospitalizations

Eye Health History

Do you wear glasses?

Do you wear contacts?

Contact Lens Brand

Last Eye Exam

Current Vision Concerns

Financial Responsibility

Payment is due at the time of service. I understand I am responsible for all charges not covered by insurance. Any balance sent to collections may incur fees up to 35% plus interest of 1.75% monthly (21% annually).

Consent & Acknowledgment

I consent to examination and treatment and acknowledge receipt of privacy practices.

Patient Signature

Date
