Fulton County

Vision Services

PATIENT INFORMATION

1162 N. Shoop Ave.
P.O. Box 374
Wauseon, OH 43567
(419) 335-3055

Date:_____

Patient's Full Name:_____
First Initial Last

Parent/Spouses' Name:_____

Home Address:_____Home Phone:_____

_____
City State Zip

Date of Birth:_____Age:_____Marital Status: S M W D

Patient's Social Security Number:_____

Employer:_____Business Phone:_____

Family Physician:_____Drug Allergies:_____

Medications:_____

Has any member of your immediate family ever had an exam in our office? Yes No

Name(s):_____Referred by:_____

Vision Insurance Carrier:_____

Policy Number:_____

Medical Insurance Carrier:_____

Policy Number:_____

PLEASE INDICATE PAYMENT CHOICE: CASH/CHECK VISA/MC/DISCOVER

EXAMINATION FEES ARE DUE AT THE TIME OF EXAM. IN ORDER TO MAINTAIN THE HIGHEST QUALITY OF PATIENT CARE, ONE-HALF OF THE CHARGE FOR EYEWEAR OR CONTACT LENSES IS PAYABLE WHEN ORDERING, WITH THE BALANCE DUE AT THE TIME THEY ARE DISPENSED. ALL UNPAID BALANCES ARE SUBJECT TO A 1.5 PER MONTH CHARGE OR 18% A YEAR CHARGE. THERE IS A $20.00 CHARGE FOR ANY RETURNED CHECKS.

As the patient or patient's guardian, I acknowledge responsibility for payment of all services rendered and agree to pay any collection expenses on accounts over 90 days.

Signed:_____

Member
American Optometric Association
TM