WELCOME TO MOUNTAIN VIEW EYE

Name:_____ Mr. Mrs. Miss Ms. Suffix:____
(First) (MI) (Last)

Birth Date: ____/___/_____ Age:_____ Nickname:_____ Male:___ Female:____

Minor: Y/N Marital Status: Single___ Married___ Divorced_____ Widowed____

Race: _____ Primary Language:_____ SSN: _____

Address: _____ City:_____State:_____ Zip:_____

Home Phone: _____ Cellphone:_____ Work Phone: _____

Email Address: _____
(Necessary for notifying purposes only and will not be given to any 3rd party)

Best way to reach you: Home phone Work phone Cell phone Text Email

Occupation:_____ Place of employment: _____

Emergency Contact:_____ Phone: _____

Primary Care Physician:_____

Payment for services including copays, are due at check out. ***Mountain View Eye provides additional specialized testing that may be billed to your regular 'major medical' health insurance. In the event any of these tests are necessary, our insurance department will handle all billing for these claims. If your insurance does not pay or is out of network with our office, you will be responsible for any amount not covered by insurance. By signing this form, you acknowledge and agree to our terms.

Signature: _____ Date: _____

Please return this form to the front desk when you have finished