Welcome to Our Office

Patient Information

Last name_____ First name_____

MI____

Address_____
Street City State Zip

Home #_____ Work #_____ Nickname _____

Sex (circle) M F Birthdate_____ Marital Status S M D W

SSN_____ Employer_____ Occupation_____

Race _____ Ethnicity _____ Communication Preference: Text Email Telephone

We are able to confirm and remind you of upcoming appointments using email and text messages!*

Cell #_____ Email_____

Responsible Party Information (If other than patient)

Name _____ Birthdate_____
First MI Last

Employer_____ SSN_____ Relationship_____

Payment Policy & Acknowledgement ***Please read and initial next to each statement.***

_____ Payment in full is expected at the time professional services are rendered and/or materials are ordered. We are happy to file insurance when applicable. Accounts 30 days past due may be subject to a charge of 1.5% per month.

_____ Failure to pay balances in the allotted time will result in patient incurring additional costs of collection including, but not limited to, attorney or legal fees, collection agency fees and finance charges.

_____ If insurance is filed on my behalf, I authorize my insurance benefits to be paid directly to Catino Eye Care Center.

_____ I agree that unless Catino Eye Care Center and my insurer have a prior agreement, I am personally responsible for all non-covered services, co-pays and deductibles.

_____ I authorize the release of medical information to insurance carriers or other physicians if it is deemed necessary by my optometrist for financial or consultative purposes.

Patient/Responsible Party (*Please print*) _____ Relationship_____

Patient/Responsible Party (*Please sign*) _____ Date_____