

Olson Optical Welcomes You To Our Office !

Please complete this form accurately. We know it may seem repetitive to ask you if any of the information below has changed since your last visit but it helps us do the best job possible for you! This information becomes part of your permanent record and as such is held in complete confidence unless you authorize its release in writing. Please see our Notice of Privacy Policy.

Name _____

Address _____ City _____ State _____ Zip _____

Phone: Home: _____ Cell : _____

Work Place: _____ Work Phone: _____ Ext _____

Date of Birth: ____/____/____ Age _____ Social Security Number ____/____/____

Spouse: _____ Parent(s) if a minor: _____

E-Mail: _____

*****NEW Website** www.olsonoptical.com *** This is a great opportunity to take care of your vision care details online!! Enjoy checking out our new site, learning about us and even ordering your next contacts at unbeatable prices to be direct delivered to you all without leaving home!

****We will contact you at any of the above addresses or phone #'s unless otherwise instructed.****

Whom can we thank for recommending you to our office? _____

Ask us about our referral program

INSURANCE INFORMATION

Due to the diverse nature of many eye conditions, disorders and procedures, some of the services we provide are covered by Major Medical Insurance rather than standard vision coverage. Please indicate any plans in which you participate. **Please present a copy of your insurance card(s) or any discount plan to the receptionist at each visit.**

PAYMENT POLICY

Payment is expected at the time services are provided. The complete balance is due when your order is delivered. We accept the following forms of payment: Cash, Check, Debit or Credit Card. This also applies if you are waiting for payment from insurance or a flex account. If there are any questions concerning your bill, please do not hesitate to ask. **Your signature below indicates that you have read, understand and agree to all of the above policies. Thank you!**

I certify that all information presented herein is correct and accurate to the best of my knowledge. I agree to have this information placed in my permanent record at this office. This information can only be changed by me in writing. This information will only be released in accordance with this office's Notice of Privacy Policy.

SIGNATURE OF RESPONSIBLE PARTY

(Must be 18 years of age to sign)

Date

PLEASE CONTINUE ON THE OTHER SIDE OF THIS FORM →

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ABOUT YOUR EYES AND GENERAL HEALTH

- * Are you experiencing any specific problems with your eyes? Yes No
* What are they? _____
- * Do you have any health problems/conditions such as diabetes or high blood pressure? Yes No
* What are they? _____
- * If having your eyes dilated today, do you have a driver with you? Yes No
- * Do you take any medication for anything? Yes No
* What do you take? (Please include over-the-counter medication, vitamins, herbal supplements, pre-natal vitamins, etc.)

- * Do you currently wear contact lenses? Yes No
* Do you change your contact lenses (are they disposable)? Yes No
* How frequently? _____
* What brand of lenses do you wear? _____
- * Would you like to wear contact lenses? Yes No
* Are you interested in a free contact lens "trial"? Yes No
- * Do you currently wear glasses? Yes No
* How old are your current glasses? _____
* Are you bothered by glare and reflections when you drive at night? Yes No
- * Do you spend time working on a computer? Yes No
* Approximately how much time per week? _____
- * If elsewhere, when was your last eye exam? _____
- * When was your last general medical exam? _____

I understand that this office will act as my agent in obtaining payment from my Insurance company; however, I further understand that I am ultimately responsible for my bill, including services not covered by Medicare or my Supplement.

I understand that in the course of providing services to me, this office creates, stores and receives information that identifies me. I authorize this office to use and disclose this identifying information as necessary for my treatment, payment and healthcare operations.

I authorize payment from any Insurance company to be made directly to this office.

I acknowledge that I have received a copy of this office's Notice of Privacy Practice.

I permit a copy of this authorization to be used in place of the original.

Name (please print) _____

Signature _____ Date _____

Thank you for selecting our office for your vision care. If you need any assistance or have questions or suggestions, please don't hesitate to let us know. We are here to serve you!