

***So Nice to See you Again!***

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](http://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**

**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!

**PLEASE CONTINUE ON THE OTHER SIDE OF THIS FORM →**

**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.)
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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**

***Thank you!***