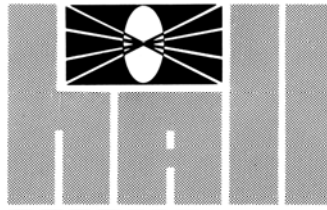


**NAMES OF OTHER FAMILY MEMBERS
WHO ARE PATIENTS HERE:**

FOR OFFICE USE ONLY

NEWSLETTER YES / NO

WELCOME CARD ___ M / F



LAKE MURRAY **OPTOMETRIST** SAN CARLOS
OPTOMETRIC CENTER

PLEASE FILL IN THE FOLLOWING FORM, ESPECIALLY THE HIGHLIGHTED AREAS.

MR. ___ MRS. ___ MS. ___ MISS ___ DR. ___ **BIRTHDATE** _____

FIRST NAME _____ LAST NAME _____

DRIVERS LICENSE# _____ **SS#** (needed for some insurances) _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ NAME OF Spouse/Parent/Guardian _____

PLEASE INDICATE BY A * WHICH PHONE NUMBER YOU PREFER US TO CONTACT YOU AT

EMPLOYER _____ HOME PHONE (____) _____

BUS. PHONE (____) _____ CELL PHONE (____) _____

BUS. ADDRESS _____ **E-MAIL ADD:** _____

_____ OCCUPATION _____

• IN CASE OF EMERGENCY PLEASE CONTACT: _____ Phone _____

VISION INSURANCE COMPANY AND I.D.# _____

MEDICAL INSURANCE COMPANY AND I.D.# _____

DATE OF LAST EYE EXAM _____ MEDICAL DRS. NAME _____

PLEASE LIST MEDICATIONS YOU ARE TAKING _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

I give permission to Dr. Hall and staff to contact me regarding
issues of health and eyecare by mail, phone or email.

WE ACCEPT CHECKS, CASH AND ALL MAJOR CREDIT CARDS.

There will be a service charge on returned checks, missed appointments w/out notice and late payment

I UNDERSTAND THAT ALL CHARGES ARE DUE ON THE DAY SERVICES ARE RENDERED.

I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANYCHARGES MY INSURANCE DOES NOT PAY FOR.

I acknowledge that I am aware of The Privacy Act as stated by HIPAA
at the office of Dr. Jeffrey A. Hall, O.D.

PATIENT'S SIGNATURE _____ DATE _____