

NORMAN EYE ASSOCIATES

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of birth _____ Social Security No. _____ Sex M F

Place of Employment _____

Marital Status _____ Spouse's Name _____

Spouse's Place of Employment _____ Phone # _____

In Case of emergency contact _____ Phone # _____

Next of kin (other than spouse) _____ Phone# _____

Referred By _____ Family Physician _____

Insurance Company (Medical) _____ Policy # _____

Member's Social Security # _____ Member's birth date _____

Insurance Company (Vision) _____ Policy # _____

Member's Social Security # _____ Member's birth date _____

Do you participate in a flex spending account Y N

Person responsible for bill _____ Phone # _____

Address _____ Employer _____

How will you settle your account today? (Please circle) CASH * CREDITCARD * CHECK

It is customary to pay for professional services at the time they are rendered.

When materials are required, half of the fee is expected on ordering. The balance is due upon dispensing.

Thank you.

Signed (patient or guardian) _____ Date _____