Welcome to Capital Vision Care *Dr. Craig McSurdy* Today's Date _____

Patient Name _____ □ Male □ Female

Address _____ City _____ State _____ Zip _____

Preferred Phone _____ (home / cell / work) Alternate _____ (home / cell / work)

Email address _____

Would you prefer to be contacted via □ phone call □ text message □ email?

Date of Birth _____ Age _____ Marital Status S M D W

Social Security Number _____ Spouse _____

Parent or Guardian (if under 18) _____ Who referred you? _____

Family members who are patients _____

Please list the following: (attach a separate sheet if needed)

Medications _____

Medical conditions _____

Allergies (drug or otherwise) _____

Do you currently wear: □ Glasses □ Contacts □ Neither Hobbies _____

Are your contacts: □ Soft, monthly □ Soft, daily □ RGP _____

Have you worn glasses in the past? □ Yes □ No Occupation _____

Have you worn contact lenses in the past? □ Yes □ No Employer _____

Are you interested in wearing contact lenses? □ Yes □ No Insured's Name _____

Do you need OSHA approved safety glasses? □ Yes □ No Insured's SSN _____

Have you ever had eye surgery? □ Yes □ No Insured's Employer _____

If yes, what kind? □ Lasik □ Cataract □ Other _____ Insurance Company _____

WE WILL HELP YOU COMPLETE AND FILE YOUR INSURANCE CLAIMS; HOWEVER, YOU, NOT THE INSURANCE COMPANY, ARE LEGALLY RESPONSIBLE FOR THE ENTIRE BILL IF YOUR INSURANCE DOES NOT PAY.

Initials

_____ I/We hereby authorize all individuals or institutions rendering medical care and treatment to furnish Dr. Craig McSurdy with full information regarding treatment rendered, including copies of records. I/We also authorize any individual or organizations to furnish full information regarding benefits to which I/we may be entitled. A Photostat copy hereof shall be as valid as the original. I/we hereby certify that the information given in support of this claim is true and correct. Insurance claims cannot be processed without signature below.

_____ I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

_____ **Appointment Cancellation Policy Agreement:** Capital Vision Care is committed to providing all our patients with exceptional care. When a patient cancels without enough notice, they prevent another patient from being seen. Please call no later than 2:00 pm the day prior to your appointment (no later than 2:00 pm on the preceding Friday for Monday appointments). If prior notice is not given, you will be charged $40.00 for the missed appointment. Your signature below is consent to these terms.

Patient Name _____ Signature _____ Date _____

(Patient or Legal Guardian if under 18 years of age)

Payment is required at the time of service. Thank you for letting us care for your visual needs.
