Welcome To Capital Vision Care *Dr. Craig McSurdy*

Today's Date_____

Patient Name_____ ☐ Female ☐ Male

Address_____ City_____ State_____ Zip_____

Phone (home)_____ (cell)_____ (work)_____

Date of Birth _____ Age_____ Marital Status S M D W

Employed by_____ Occupation _____

Social Security Number _____ Spouse _____

Parent or Guardian (under 18) _____ Who recommended us? _____

Family members who are patients _____

e-mail address _____ Hobbies _____

Do you wear: ☐ Glasses ☐ Contact Lenses ☐ Neither

Have you worn glasses in the past? ☐ Yes ☐ No

Have you worn contact lenses in the past? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

Do you need OSHA approved safety glasses: ☐ Yes ☐ No

Please list all medications, medical conditions and allergies:

_____

_____

_____

Drug allergies:_____

Will you be paying for your services today by: ☐ Cash ☐ Check ☐ Credit Card ☐ Medicare ☐ Insurance

Insurance Company _____ Insured's Name _____

Insured's Employer _____ Insured's SSN _____

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

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. Signature_____

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

Patient Name_____ Signature _____ Date _____
(If Under 18 Years of Age, Legal Guardian's Signature)

Appointment Cancellation Policy Agreement: Capital Vision Care is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (614) 457-2081 for Northwest or (614) 224-3456 for Downtown by 2:00 pm the day prior to your appointment to reschedule. To alter a Monday appointment please cal by 2:00 pm on Friday before. If prior notice is not given, you will be charged $40.00 for the missed appointment. Please sign below to consent to these terms. Parent or guardian signature if under 18.

Signature: _____ Date: _____

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