WELCOME TO OUR OFFICE

TERI L. ALPERT, O.D.
DEBORAH A. BITTNER, O.D.

Date_________________

Name___________________________________ M or F Birth Date _______________ Age_______

Address_________________________________City_____________________________Zip_________

Home Phone (____)______________ Work (____)________________ Cell (____)_______________

Spouse's Name (If married) _________________________ Parent's Name (If patient a minor) ____________________

Employer _________________________________ Occupation ___________________________

How do you prefer we notify you when your glasses and/or contact lenses are ready?

Phone: home___ work___ cell___ email___ Any or all of these ____ OK to leave message? Y or N

Email address (if you prefer to be contacted by email)____

If you have Vision Insurance: Name of Company_______________________________________

If you have Major Medical Insurance: Name of Company_________________________________

Name of Insured __________________________________ Birth Date of Insured_____________

Insured's social security number (last four numbers OK) or ID number___________________________

Patient's social security number (last four numbers OK) (if different than above)__________________________

Do you wear: Glasses______ Contact Lenses ______ Type: hard/gas perm______soft_______

Whom May We Thank for Referring You to Our Office____
(If phone book or online phone book, do you remember which one?)

I acknowledge that I was offered the opportunity to read and/or receive our Notice of Privacy Practices.

I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Teri L. Alpert, O.D. I understand that I am financially responsible for all charges whether or not insurance pays a portion of the charges.

Patient's or Responsible party's signature____

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED AND MUST BE PAID IN FULL BEFORE ANY MATERIALS ARE DISPENSED