

Friedman Optometry

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Ms.

Mrs.

Mr.

Dr. _____
LAST NAME , FIRST NAME, MIDDLE INITIAL

DATE

ADDRESS

DATE OF BIRTH (DOB)

CITY STATE ZIP CODE

HOME PHONE NUMBER

EMAIL ADDRESS

MOBILE PHONE NUMBER

MARITAL STATUS: SINGLE MARRIED

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER: _____

PREFERRED METHOD OF CONTACT: MOBILE PHONE HOME PHONE EMAIL TEXT MESSAGE

IS THIS YOUR FIRST VISIT TO OUR OFFICE? YES NO

HOW DID YOU HEAR ABOUT US?

FAMILY/FRIEND REFERRING DOCTOR GOOGLE YELP INSURANCE LIST OTHER: _____

*** PLEASE SILENCE CELL PHONES DURING YOUR VISIT TO OUR OFFICE ***

PAYMENT POLICY

ALL SERVICES MUST BE PAID FOR IN FULL WHEN RENDERED. MINIMUM DEPOSIT REQUIRED WHEN MATERIALS ARE ORDERED. MATERIALS MUST BE PAID FOR IN FULL WHEN DISPENSED.

REFUND POLICY

ALL SALES FINAL. REFUNDS ARE CONSIDERED ON A CASE BY CASE BASIS.

FOR OFFICE USE ONLY

Today's Appointment Type: _____

CVE _____ CVE/DRE _____ DRE _____ IMAGING/PACHY _____ G/OCTNERVE _____

G/OCTNERVE _____ IMAGING _____ OCTNERVE _____ OCTMACULA _____ OCTANT _____

TOPOGRAPHY _____ MFIELD _____ GFIELD _____ ANTSEGIMAGE _____

CLFU _____ CLFITTING _____ CLTRAINING _____ FU _____ OTHER _____

SVDIST SVNEAR PAL _____ FT28 VDT/NEAR VDT A/R TRANS BLUE POLY HI

SUNGLASSES CL _____ MYOPIA MANAGEMENT PRISM