Date_____

Dr. Paul S. Crismon Optometry

Name: _____ Email Address: _____

Address: _____ Date of Birth: _____ Age:_____

City: _____ State:_____ Zipcode:_____ Sex: Male Female

Cellphone: _____ Spouse (or parent) name:_____

Home Phone: _____ Spouse (or parent) work phone:_____

Work Phone: _____

Social Security Number: _____

Employer: _____

Occupation: _____

We will do everything possible to find out what your insurance company will cover before you leave the office.

Any amount not paid by the insurance company is always the patient's responsibility.

ALL SALES ARE FINAL. NO RETURNS OR EXCHANGES.

_____ _____ _____

Signature/Parent Signature (if patient is a minor) Date