



Broadway Eye Center

ver08/10

Dr. Robert (Bob) Day, Jr., Therapeutic Optometrist
Dr. Ashley Huff, Therapeutic Optometrist

Welcome to our office. Please complete the following:

Patient's Name: _____

Nick Name: _____ Sex: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____ Cell Phone: (____) _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Employment: Full Time ___ Part Time ___ Student ___

If patient is child,

Parent's names: _____

Address (if different): _____

City (if different): _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Method of Payment: Cash ___ Check ___ Discover ___ Mastercard ___ Visa ___

Medical Care Plans: Medicare ___ Blue Cross/Blue Shield ___ CIGNA ___ United Health ___ Pacificare ___

Well-Vision Care Plans: Vision Service Plan (VSP) ___ Vision Care Plan (Humana VCP) ___ CIGNA Vision ___
Superior Vision ___

Insured employee's Name: _____ SS #/ ID# _____ Date of Birth ____/____/____

Employer: _____

Please sign the following:

I acknowledge that I received a copy of the NOTICE OF PRIVACY PRACTICES of Broadway Eye Center/Metroplex Optical. I also acknowledge that after my insurance companies have fulfilled their obligations for services rendered, I am responsible for the patient's share including deductibles and coinsurance. Further, I acknowledge that if I am not eligible through my insurance, I am responsible for the full payment for services rendered.

Signature of Patient or Parent/Guardian: _____ Date: _____

How did you learn of our office? VSP list ___ Blue Cross list ___ Other insurance list ___

Office location ___ Internet/Website ___ Yellow Pages ___

Know doctor ___ Friend suggested ___ Relative suggested ___