

**WELCOME TO OUR OFFICE
MAIN STREET EYE CARE**

Date: _____

- Married
- Single
- Other

Patient's Name: _____ M – F Age _____ Date of Birth: _____

Address _____ City: _____ State: _____ Zip Code: _____

May we call you there?

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Yes ___ No ___

E-mail Address: _____

Occupation: _____ if Student: School _____ Grade _____

Employer Name & Address: _____

**Parents/Guardian (if applicable) _____

(if different than above) Address _____

Insurance: _____ (please present your card/information for our records)

Policy Holder: _____ Policy Holder – Date of Birth _____

(if different than above) Address _____

Emergency Contact: _____ **Phone Number:** _____

Date of Last Eye Exam _____ **Name of Previous Eye Doctor** _____

Questions, Problems or Concerns to be addressed: _____

Are you planning to get new glasses? _____ Are you happy with the ones you have? _____

Do you currently wear contact lenses? _____ Are you interested in contact lenses? _____

Current Contact Lens Brand: _____

Disinfecting Solution: _____

I acknowledge that I have been given the opportunity to review a copy of Dr. J.P. Michaud, OD / Main Street Eye Care's Notice of Privacy Practices, (HIPAA). I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination.

I understand that I am financially responsible for all charges whether or not paid by insurance and that I may be charged a \$75.00 fee for missed or canceled appointments without 24 hr. notice.

Payment is due at the time services are rendered.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: _____

Please Turn Over to Complete Medical History Form