Welcome to
BEALS OPTOMETRY

Where the difference is Clear. The difference is Care.

Name:_____ Date of Birth_____
Nickname: (Please call me): _____

Address_____
City_____ State_____ Zip Code_____

Home Phone_____ ☐ (please check preferred contact number)
Cell Phone_____☐ okay to text? ___
Work Phone_____☐
E-mail_____

What is your current occupation status?

- ☐ Employed Employer:_____ Occupation:_____
- ☐ Student Current grade_____
- ☐ Retired
- ☐ Other: _____

If Child: Parent(s): _____

Do you use a computer? _____ _____ hours/day

Whom may we thank for referring you? _____

Emergency Contact:_____ Relationship_____

Please present all insurance information at the time of your exam.

Signature for release to Insurance:

I authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to the doctor, insurance benefits otherwise payable to me. I understand that insurance is a contract between myself and the Insurer and Beals Optometry cannot guarantee payment from your insurer. I also understand that my insurance carrier may pay less than the actual bill for services and or materials. I agree to be responsible for payment of all services and materials rendered for myself or my dependent.

Signature of Patient (or Parent if Minor)_____Date_____

Signature for HIPPA:

Our notice of privacy practices ensures the confidentiality of your private information. A copy of the HIPPA notice is available for your review. I wish to continue my care with Beals Optometry under the terms.

Signature of patient (or parent if minor)_____Date_____