WEST VISION

Dr. Jacob C. West, O.D.
Therapeutic Optometrist
Glaucoma Specialist

Today's Date: _____

Name: _____
AKA: _____
Address: _____
_____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Employer: _____
Occupation: _____
E-Mail: _____

How would you like to be contacted?
○Phone ○E-Mail ○Postal ○Text

Date of Birth: _____
○Male ○Female
○Single ○Married ○Widowed
○Other: _____
Social Security: _____

How did you hear about us?

○ FACEBOOK
○ Drive by
○ Walk-In
○ Insurance
○ Yellow Pages
○ Co-Worker
○ Walk-In
○ Web: Google, Yahoo, YP
○ Other: _____
○ Referred By: _____

INSURANCE INFORMATION

Medical Insurance:_____
Insurance ID:_____
Vision Insurance:_____
Vision Insurance ID:_____

Guarantor Information: (Parent or Primary Member on Medical Insurance)
Self (LEAVE BLANK)

Guarantor's Name: _____
Guarantor's DOB: _____
Guarantor's SSN: _____
Relation to Patient: _____

AUTHORIZATION: PLEASE READ & SIGN BELOW

I certify that I have read and understand the above information to be correct to the best of my knowledge I authorize and request my insurance company to pay West Vision directly any insurance benefits otherwise payable to me.
I agree to be responsible for payment of all services rendered on my behalf of my dependents.

AND:

I authorize West Vision to realease my information to the following individuals/organizations:

X _____
Signature of patient or person responsible

X _____
Relationship to Patient