



COMPLETE FAMILY EYECARE

Dr. Christena Ward, O.D. ▪ 324 U.S. Hwy 6 ▪ P.O. 3728 ▪ Dillon, CO 80435 ▪ (970) 262-9272

Patient Information

«APPT_RSN» Acct «PAT_ACCT»

Name _____ Home Phone _____
Mailing Address _____ Cell Phone _____
City _____ State _____ Zip _____ Work Phone _____
Last 4 Digits of Social Sec # _____ Occupation _____
Date of Birth _____ Age _____ Employer _____
Hobbies _____ Email _____

How did you hear about our office?

☐ Friend, relative or patient. Who? _____ ☐ Medical provider. Who? _____
Telephone Book ☐ Qwest Dex ☐ Names & Numbers ☐ Yellow Book ☐ Newspaper Ad ☐ Other _____

Payment Information

Full payment is required at the time of service for all doctor visits, glasses, contact lenses, co-pays, deductibles and any other services or products not covered by insurance.

How will you settle your account today? ☐ Check ☐ Cash ☐ Credit Card

Vision Insurance Information

Vision Insurance Company _____ Group # _____

Primary Insurance Holder Name _____

Insurance ID / Social Sec # _____ Date of Birth _____

Relationship to Patient _____

Initial _____ Note that most eye care insurance plans do NOT cover contact lens services. These charges will be assessed separately as required.

Initial _____ Please be advised that your vision insurance plan is a contract between you and your insurance company, not our office. If issues arise regarding eligibility, coverage, payment, deductibles, copays or referrals, you are ultimately responsible for contacting and resolving the issue with your insurance company, as well as paying any outstanding balances not paid by your insurance company.

Initial _____ Be aware that if your insurance company has not paid us within 60 days, you will be responsible for paying any balance due.

Signature _____ Date _____