Friedman Optometry

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Ms.
Mrs.
Mr._____ _____
Dr. LAST NAME , FIRST NAME, MIDDLE INITIAL DATE

_____ _____
ADDRESS DATE OF BIRTH (DOB)

_____ _____
CITY STATE ZIP CODE HOME PHONE NUMBER

_____ _____
EMAIL ADDRESS MOBILE PHONE NUMBER

MARITAL STATUS: SINGLE MARRIED

PREFERRED LANGUAGE: ENGLISH SPANISH OTHER: _____

PREFERRED METHOD OF CONTACT: MOBILE PHONE HOME PHONE EMAIL TEXT POSTCARD

IS THIS YOUR FIRST VISIT TO OUR OFFICE? YES NO

HOW DID YOU HEAR ABOUT US?

FAMILY/FRIEND REFERRING DOCTOR GOOGLE YELP INSURANCE LIST OTHER:_____

* PLEASE SILENCE CELL PHONES DURING YOUR VISIT TO OUR OFFICE *

PAYMENT POLICY
ALL SERVICES MUST BE PAID FOR IN FULL WHEN RENDERED. MINIMUM DEPOSIT REQUIRED WHEN MATERIALS ARE ORDERED. MATERIALS MUST BE PAID FOR IN FULL WHEN DISPENSED.
REFUND POLICY
ALL SALES FINAL. REFUNDS ARE CONSIDERED ON A CASE BY CASE BASIS.
FOR OFFICE USE ONLY

Today's Appointment Type:_____

□CVE_____ □CVE/DRE_____ □DRE_____ □IMAGING/PACHY_____ □G/OCTNERVE_____

□R9/OCTNERVE_____ □IMAGING_____ □OCTNERVE_____ □OCTMACULA_____ □OCTANT_____

□TOPOGRAPHY_____ □MFIELD_____ □GFIELD_____ □R9_____ □R8_____ □CLEVAL_____

□CLFU_____ □CLTRAIN_____ □GONIO_____ □FU_____ □ANTSEGIMAGE_____ □OTHER_____

□SVDIST □SVNEAR □PAL_____ □FT28 □VDT/NEAR □VDT □A/R □TRANS □BLUE □POLY □HI □PRISM

□CL_____