Dr. Vaughn G. Sanders **Dr. Charles D. Heck**

WELCOME TO OUR OFFICE

Mr.
Mrs.

Miss _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____

Employer _____ Occupation _____

Spouse _____ Date of Birth _____

Spouse Employer _____

Work Phone (____) _____ Cell Phone (____)_____

IF PATIENT IS UNDER 18 YEARS OF AGE PERSON RESPONSIBLE

(This information should be the guardian that has brought the child in.)

Name _____ Relationship _____

Date of Birth_____ Home Phone (____)_____ Cell Phone (____)_____

Employer _____ Work Phone (____)_____

Payment Policy

Payment for professional service is required at the time the service is rendered. If ophthalmic materials are prescribed, a deposit is required before glasses will be ordered and the balance is to be paid in full at the time of dispensing.

If we are participating providers with your insurance we will gladly process your claim. If we are not we will be glad to assist you in filling out your forms. We request that you pay your estimated portion when services are rendered. You're responsible for payment not your insurance.

SIGNATURE _____ **DATE** _____