WELCOME TO OUR OFFICE
MAIN STREET EYE CARE

Date: _____

☐ Married
☐ Single
☐ Other

Patient's Name: _____ Age_____ Date of Birth:_____

Address _____City: _____State: _____Zip Code:_____

May we call you there?

Home Phone: _____ Cell Phone: _____ Work Phone: _____Yes __ No __

E-mail Address: _____

Occupation: _____ if Student: School _____ Grade ___

Employer Name & Address: _____

**Parents/Guardian (if applicable) _____

(if different than above) Address_____

Medical Insurance: _____ (please present your card/information for our records)

Vision Insurance: _____

Policy Holder: _____ Policy Holder: Date of Birth_____

Policy Holder Last 4 of Social Security Number: _____

Policy Holder Address_____
(if different than above)

Emergency Contact: _____Phone Number: _____

Primary Care Physician_____ Phone_____

Pharmacy_____Address_____Phone_____

I acknowledge that I have been given the opportunity to review a copy of Dr. J.P. Michaud, OD / Main Street Eye Care's Notice of Privacy Practices, (HIPAA).
I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination.
I understand that I am financially responsible for all charges whether or not paid by insurance and that I may be charged a $75.00 fee for missed or canceled appointments without 24 hr. notice.
Payment is due at the time services are rendered.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: _____