Calvin F. Graham, OD & Staff

Welcomes you and your family to our office.

Please fill in **all** the information requested below.
We need the information to create or update your patient record,
and is required by law: at least once per year.

Thank you for your cooperation.

Patients Name:_______________________________________, ____/___/______ ____
First MI Last Date of Birth AGE

Mailing Address:____
Street or P.O. Box and Apt # City State Zip

_____/____/______ ____ Male / Female
Social Security Employer / Occupation or School and Grade

Single Married ( ) _______--_________ ( ) _______--_________

Widowed Divorced Other Home / Cell / Work / 2nd Cell Phone

Responsible Party or_______________________________________ ____/____/______
Insureds Name First MI Last Date of Birth

Relation to Patient: ___________________________________ ______/_____/________
Social Security #

If patient is under 18 or If someone other than the patient is accepting responsibility for patients charges: we need their information:

Mothers Name: __________________ DOB ____/____/____ SS# _____/____/______

Fathers Name: ___________________ DOB ____/____/_____ SS# ____/____/______

Spouses' Name: _________________ DOB ____/____/_____ SS# ____/____/_______

I the undersigned give my consent for Graham Optical / Calvin F Graham, OD to examine my eyes and consent to release any information needed to complete any insurance claim, call in or fax prescriptions for medication, send information to referring or primary care doctor that I request. I also authorize any and all insurance payments to be sent directly to Calvin F Graham, OD. I also **understand that any insurance coverage quoted to me on the day of my visit is only what my insurance has told Graham Optical employees and is no guarantee of benefits or payment and that I am ultimately responsible for all charges regardless of insurance reimbursement. If my insurance company has not paid within 6 months; I will be expected to pay the remaining balance I also agree to be financially responsible for all items ordered for me by Graham Optical in good faith.**

Patient or
Responsible Party's Signature ________________________________ Date ________