Dr. Ralph Williams
Dr. Leah McConnaughey
Dr. Khristopher Ballard

WELCOME TO OUR OFFICE: We are glad that you have chosen us as your vision care provider. Please complete this form and return it to our receptionist so that we can provide you with the best possible care.

Name: _____Preferred/Nick Name_____Date of Birth_____

Address:_____Home Phone: _____

City:_____State:_____Zip:_____Work Phone:_____

Email Address:_____Cell Phone:_____

Occupation:_____ Employer:_____

Hobbies:_____Sports:_____

Marital Status: Single Married Divorced Widowed Spouse/Parent/Guardian:_____

Patient Social Security#:_____Family Physician/Phone#:_____

Primary Insurance Info:	**Secondary Insurance Info:**
Group Name:	Group Name:
Address	Address
Insured's Name:	Insured's Name:
ID #	ID #
Group #	Group #
Insured's Date of Birth:	Insured's Date of Birth:
Insured's SS#	Insured's SS#
Patient relation to insured:	Patient relation to insured:

Emergency contact: Name:_____Relationship:_____Phone:_____

Physician's release and agreement: I hereby authorize payment directly to Dr. Ralph Williams, Dr. Leah McConnaughey, and Dr. Khristopher Ballard of benefits due to me from my insurance company otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). A copy of this authorization may be used in lieu of the original. I authorize the holder of medical or other information about me to release to the Social Security Administration and Health care Financing Administration or its intermediates or carriers any information needed for this or a related Medicare claim. I request payment of medical insurance benefits either to myself or to the part who accepts assignment. I understand that I am financially responsible for charges not covered by this authorization. If I fail to pay any outstanding balances, I will also incur charges associated with the collection of these fees.

I understand I will be responsible for any fees incurred because I did not provide accurate insurance information. This includes not getting authorizations when required.

Patient Signature:_____Date:_____

I have read and understood the Notice of Privacy Practices: _____
Sign and date

Please be sure to bring your current glasses and sunglasses with you so we can evaluate your visual needs. If you wear contact lenses, please bring your boxes with you and wear the contact lenses to the exam. Finally, please bring a list of current medications both prescription and over the counter.