H. ROBERT DYKES, O.D.
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South Lake Tahoe, CA 96150
(916) 544-2020

NEW PATIENT FORM

NAME _____ BIRTHDATE _____ AGE _____
LAST FIRST MIDDLE

MAILING ADDRESS _____
PO BOX CITY STATE ZIP

PHYSICAL ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE (____) _____ SOCIAL SECURITY # _____

EMPLOYER _____ OCCUPATION _____ HOW LONG _____

ADDRESS _____ BUSINESS PHONE _____

SEX ____ MARITAL STATUS M S W D (circle one) SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____ BUSINESS PHONE (___) _____

NEAREST RELATIVE OTHER THAN SPOUSE _____

ADDRESS _____ PHONE (___) _____

RESPONSIBLE PARTY _____ ADDRESS _____

INSURANCE _____ DRIVER'S LIC. _____ STATE ___ EXPIRES _____

REFERRED BY _____

I hereby authorize: consent for treatment, assignment of insurance benefits and responsibility for collection and or lawyers fees for unpaid bills and finance charges.

PAYMENT POLICY

I have no eye insurance, so I elect to pay in full at each visit as treatment progresses with ***CASH, CHECK, VISA*** *or* ***MASTERCARD.***

I have no eye insurance so for larger fees I elect to pay one-half down (to cover lab expenses) and the balance on delivery date.

I have eye insurance. I elect to pay:

a.) the deductible each year on the first visit and out of pocket portions as treatment progresses with ***CASH, CHECK, MASTERCARD*** *or* ***VISA.***

b.) one-half down on larger fees on the examination date and the balance on delivery date of eyewear.

SIGNATURE _____ **DATE** _____
Patient or parent of minor