NORTHWEST OPTOMETRIC CLINICS

Date ______________ ◻ Tigard Optometric Clinic ◻ Barbur Optometric Clinic

Last Name_________________________________ First__________________________ MI ___

Address___________________________________ City_______________ State___ ZIP______

Birthdate_____________ Email ____

Cell Phone ________________ Home Phone _______________ Work Phone _________________
(please indicate best number to contact you)

◻ Male ◻ Female

Reason for visit____

Referred by: _________________________ (name) ◻ Insurance Co. ◻ Internet ◻ Other

Currently use: ◻ distance vision glasses ◻ reading glasses ◻ contact lenses
◻ bifocal ◻ trifocal ◻ progressive lens ◻ computer glasses

Occupation ______________________________ Employer________________________________

Hobbies ◻ sports ◻ music ◻ computers ◻ woodworking
◻ gardening ◻ sewing ◻ hunting/fishing ◻ other____________

Are we billing vision insurance? ◻ yes ◻ no If yes, please indicate which one:

◻ Vision Service Plan ◻ Eyemed ◻ Providence ◻ Moda ◻ Blue Cross ◻ Lifewise
◻ Pacificsource ◻ HealthNet ◻ OHP ◻ Medicare ◻ Other

ID #________________________ Group#__________________ Phone#_____________________

Person responsible for this account:

◻ Self ◻ Other __________________________________ Birthdate ____________

Phone: ___________________ Relation to patient __________________

Northwest Optometric Clinics will bill your insurance company as a courtesy, provided complete and accurate information has been supplied. A quote of insurance benefits does not guarantee payment. We do not bill secondary insurance.

I authorize payment of benefits to Northwest Optometric Clinics. Ultimately, I understand I am responsible for all charges not covered by or denied by my insurance company. I realize failure to pay my balance in full will negate any warranties on dispensed products.

Signature ____ Date_____________