

Welcome To Our Office

Dr. Carolyn M. Wong, O.D.
Dr. Grace K. Wong, O.D.

For faster service, please complete the following confidential information and sign on the bottom prior to arriving at our office. If you would like assistance with completing the form, our staffs will be happy to assist you when you arrive.

Mr. / Mrs. / Miss / Ms. / Dr. _____ Single / Married / Divorced / Widowed

NAME _____ Date of Birth ____/____/____
(Please use legal name) LAST FIRST M.I.

MAILING ADDRESS _____
STREET ADDRESS

CITY STATE ZIP CODE

PHONE NUMBERS (H) _____ (W) _____

CELL PHONE _____ EMAIL ADDRESS _____

OCCUPATION _____ EMPLOYER _____

If the patient is a child, Parent's name _____
LAST FIRST M.I.

Address (if different) _____
STREET ADDRESS CITY STATE ZIP

Vision Insurance Carrier _____ Insured Name _____

Employer _____ Occupation _____

Insured ID or SS# _____ Policy or Group# _____

Insured Date of Birth ____/____/____ Relationship to patient _____

Medical Insurance Carrier _____ Insured Name _____

Insured ID or SS# _____ Policy or Group # _____

Insured Date of Birth ____/____/____ Relationship to patient _____

In case of an emergency, who should we contact?

Name _____ Relationship _____ Phone _____

Whom may we thank for referring you?

Referred by _____ or Yellow pages _____ or Insurance _____

I hereby authorize payment directly to Dr. Carolyn Wong all insurance benefits otherwise payable to me for services rendered if Dr. Wong is able to accept assignment. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf or my dependents. Payment is due at the time services are rendered.

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I authorize the use of this signature on all insurance submissions.

Signature _____ Date _____