

GRESHAM VISION CENTER
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GRESHAM, OR 97030
503-665-3813

SANDY VISION CENTER
39400 PIONEER BLVD #3
SANDY, OR 97055
503-668-4313

www.greshamvisioncenter.com

WELCOME TO OUR OFFICE

Name _____
FIRST LAST

Date of last Exam _____

Mailing Address: _____

Date of Birth _____ Age _____ M F

City _____ State _____ Zip: _____

Required SS# _____

Home Phone _____

Employer _____ Phone _____

Email Address _____

Cell Phone _____

Vision Ins _____

Medical Ins _____

Member Name _____

Member Name _____

Member ID# _____

Member ID# _____

Member SS# _____ Date of Birth _____

Member SS# _____ Date of Birth _____

Reason for Today's Visit? _____

Who may we thank for referring you to our office? _____

****We are required to include the following information in your Health Record by the Centers for Medicare/ Medicaid Services****

Race: White Asian Decline to Answer
Black or African American American Indian
Native Hawaiian/Pacific Islander Other _____
(Please Circle One)

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Decline to Answer
(Please Circle One)

Please make sure you have read our financial policy and understand that what your insurance quotes us is not a guarantee of payment.

I have read and understood the information on this form, the form regarding payment agreements and collection policies, release of medical information, assignment of insurance benefits and notice of privacy practices under HIPAA.

X _____ Date _____

Patient or Guardian's Signature

Verified By: _____ Date: _____ Verified By: _____ Date: _____ Verified By: _____ Date: _____