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

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WELCOME TO OUR OFFICE

Name_____ Date of last Exam_____
FIRST **LAST**

Mailing Address:_____ Date of Birth_____ Age_____ M F

City_____State_____Zip:_____ Required SS#_____

Home Phone_____ Employer_____ Phone_____

Cell Phone_____ Email _____

Vision Ins_____ Medical Ins_____

Member Name_____ Member Name_____

Member ID#_____ Member ID#_____

Member SS#_____Date of Birth_____ Member SS#_____Date of Birth_____

Reason for Todays 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:_____