DAVID J. SHEN, O.D.
DIRECTOR OF EYECARE SERVICES

vue
OPTIQUE

WENDY SHEN
DIRECTOR OF CLIENT SERVICES

Date _____ Referred By _____

Last Name _____ Date of Birth _____

First Name _____ Social Security # _____

Address _____ Marital Status _____

City _____ Employer _____

State _____ Zip Code _____ Occupation _____

Home Phone _____ Date of Last Eye Exam _____

Work Phone _____ Wear Glasses? _____

Cell Phone _____ Circle For Reading For Driving Always

Email Address _____ Wear Contact Lenses? _____

What Type? Soft Gas Perm Bifocal
Daily or Extended Wear

Insurance Information

Patient Relationship to Insured Self Spouse Child Other
Insurance Plan Name _____
Policy Group # _____ Insured's I.D. # _____
Insured's Name (if different from above) _____
Insured's Address _____
Insured's Birth Date ___/___/___ Insured's Employer _____

Patient's or Authorized Person's Signature I authorize the release of any medical or other information necessary to process my insurance claim(s). I understand that I am responsible for any uncovered expenses and payment is due at the time of service.
Signed _____ Date _____

By signing below, I agree that I have been given a copy of the *Notice of Privacy Practices for Protected Health Information.*
Signed _____ Date _____

436 Main Street
Franklin, Tennessee 37064
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