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Doctors of Optometry

## Patient Registration

WELCOME- THANK YOU FOR CHOOSING  
OUR OFFICE FOR YOUR VISION HEALTH CARE

Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last Eye Exam \_\_\_\_\_

Patient Name Mrs. Ms. Miss  
(Circle) Mr. Dr. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

If Child \_\_\_\_\_ School Attending \_\_\_\_\_  
Parent Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employed By \_\_\_\_\_

Do you work on a Computer? Yes No

Referred to our office by \_\_\_\_\_

Social Security # \_\_\_\_\_

Insurance Information: Circle Yes or No for each

•Vision Insurance Yes No Carrier's Name \_\_\_\_\_

If you are not the member, member's name \_\_\_\_\_  
and Social Security \_\_\_\_\_

•Medical Insurance Yes No Carrier's Name \_\_\_\_\_

•Medicare Yes No Medicare # \_\_\_\_\_

Office policy for payment:

In an effort to keep our fees at a minimum and avoid the extra expense  
to you of mailing statements, we ask that:

1. A deposit is paid on the day of service
2. The balance is paid on the day of delivery

If the above policy is not followed, a service charge will be added to all  
accounts over 30 days.