Please answer these questions so we may better serve you.			
Last Name		Gender	❑ Male ❑ Female
First Name		Date of Birth	
Guardian if child		Age	
Title		Social Security #	
Nickname		❑ Single ❑ Married	
Address		Employer	
Address		Occupation	
City		Referred by	
State / ZIP		Date Last Exam	
Home Phone			
Day Phone			
Cell Phone			
Pager			
Fax			
E-Mail			
Medical Insurance1		Plan Name	
❑ HMO ❑ PPO ❑ POS ❑ EPO		Co-Pay	
Other ______________________		Insured: ❑ Self ❑ Spouse	
Medical Insurance2		Plan Name	
❑ HMO ❑ PPO ❑ POS ❑ EPO		Co-Pay	
Other ______________________		Insured: ❑ Self ❑ Spouse	
Vision Insurance		Insured: ❑ Self ❑ Spouse	
Insured Name		Insured DOB	

I request that insurance benefits be paid to Dr. Steensma. I allow the release of any personal information necessary to determine insurance benefits. I understand that Dr. Steensma's office will verify insurance benefits as a courtesy. In the event of the insurance company denying benefits, I will be responsible for paying the charges. We hope that you will find your visit to our office to be a pleasant and interesting experience. If your eyes are dilated during this visit, your vision may be blurred and lights will be bright.

DO NOT LEAVE UNTIL YOUR VISION IS SAFE FOR DRIVING!

Name:________________________________ Date:____________

Sign:________________________________ Guardian Sign:______________________________