



1409 Washington Ave Golden, CO 80401 303-271-1400

Demographic Information:						
Legal Name:		Preferred Name:				
Date of Birth: Age: _		Preferred Contact Method: Cell Home Email				
Gender: S	Sex (at birth):]				
	Please circle	Cell Phone:				
	Male					
 Other or Non-binary 	Female	Harris Blacks				
 Prefer not to answer 		Home Phone:				
Pronouns: (select all that apply)						
o He/him		Email Address:				
She/her						
They/them						
o Other:						
Race:		Address:				
 Caucasian descent 						
 African descent 						
 Native American 						
 Asian descent 		City: State: Zip Code:				
 Native Hawaiian/Pacific Isl 	lander					
 Prefer not to answer 		In case of emergency, please contact:				
Ethnicity:		Name:				
 Hispanic 						
 Non-Hispanic 		Cell: Relation: Spouse Child/Parent Other				
 Prefer not to answer 		Relation: Spouse Child/Parent Other				
Employer:		Occupation:				
Insurance Information						
Name of Medical Insurance:						
Primary's Information: Same as above □						
Name: Date of Birth: Phone number:						

We willingly accept payment on your behalf from most vision insurance plans. We will file your insurance claim for you whenever possible. We provide these additional services at no additional charge as a courtesy to our patients. If we will be filing an insurance claim for your visit or eyewear today, you must present proof of insurance *prior* to the initiation of services. We will always attempt to contact your insurance company to verify your eligibility and your benefit details prior to the initiation of services. Unfortunately, despite out best efforts, insurance companies cannot guarantee benefit information until they receive a bill. It is very important for you to understand that knowledge of your insurance eligibility and benefits is ultimately your responsibility and that you are ultimately responsible for all charges that you incur. It is our policy to have a copy of the insurance card so we may bill the insurance effectively. You are responsible for applicable co-payments and payment of your medical care within a reasonable time, regardless of billing status. Services not covered by your insurance are your responsibility.

Please check any of the following conditions by which you or a family member has been affected: Condition SELF FAMILY Blindness Cataracts Glaucoma Macular Degeneration Reinal Detachment Head injury High Blood Pressure Thyroid Disease Altergies Asthma Migraines Lazy/Turnet Eye Autoimmune Disorder Which one? Cultary Migraines (if self) Frequency? Altoir Treatment: Diabetes (if self) Treatment: Diabetes (if self) Treatment: Diabetes Other? Are you currently taking any medication? Please include both prescription and over-the-counter, as well as the dosage and the reason. Are you currently taking any medication? Please include both prescription and over-the-counter, as well as the dosage and the reason. The above information is correct to the best of my knowledge. Pease notify us at any time if you have any special needs or restrictions regarding the standard use of your protected health information. The above information is correct to the best of my knowledge. Patient/Guardian Signature: Date:									
these applies to you: corrective surgery (PRK, Lasik, Cataract, Edatacts					Please indicate which of	Have you had			
Condition SELF FAMILY Do you wear: (Fig. Lasik, Cataracts Cataract					these applies to you:	-			
Cataracts Cata		SEI	_	EAMII V	-	(PRK, Lasik, Cataract,			
Calaracts Glaucoma		JLL		I AWIL I	Do you wear:	etc)? If so, when? With			
Glaucoma Macular Degeneration RGP Soft (daily, monthly, thead Injury Unity					Contacts?	whom?			
Macular Degeneration Refinal Detachment Head Injury High Blood Pressure Glasses? Both? Soft (daily, monthly, unsure) Glasses? Both? Neither? Ne						.			
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