

WELCOME TO THE OFFICE

CONFIDENTIAL - PERSONAL INFORMATION

**DR. RICHARD L. POWELL, OPTOMETRIST
3200 "O" Street Suite A Lincoln Nebraska 68510**

Today's Date _____ Social Security # _____

Name _____ M or F Date of Birth _____

Name of spouse/parent _____

Address _____ City _____

State _____ Zip _____ Phone _____ Cell Phone _____

Employed by _____ Business Phone _____

Occupation _____

School _____ Grade _____

E-mail address _____

Insurance Co and # _____

Person to notify in case of emergency (not at above address) _____

Address _____ Phone _____

How did you find our office? Phone book Internet Family/Friend

Other _____

When was your last eye exam? _____ Where? _____

Please pay for Professional Services when they are received.

Deposit required on glasses or contacts before ordering.

Payment in full at delivery.

Payment Plans: Cash Check Credit Card Automatic Bank Credit Card Deductions

ONE TIME AUTHORIZATION

NAME OF BENEFICIARY

HI CLAIM NUMBER

I request that payment of authorized insurance benefits be made on my behalf to Dr. Richard Powell for any services furnished to me by that physician. I authorize any holder of medical information about me to be released to insurance and its agent any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

"The difference is clear--the difference is care."