Oliver Opticians
5776 Dow Ave.
Alexandria, VA 22314

REGISTRATION FORM

(PLEASE PRINT)

PHONE: (703)567-0314
FAX: (703)567-0384

Today's Date:	• New Patient • Established Patient

PATIENT INFORMATION

Patient's Last name: First: MI:	DOB: / /	Sex: • M • F
Social Security No.:	Marital Status: •Minor •Single •Married •Divorced	Phone Number: •Cell •Home ( )
Street Address:		
City:	State:	ZIP Code:
Primary Language: • English • Spanish • Arabic • French • Chinese • Portuguese • Farsi • Japanese • Other:	Race: • Native Hawaiian or Pacific Islander • American Indian or Alaskan Native • Asian • Black or African American • White • Other:	
Ethnicity: •Hispanic •Not Hispanic or Latino / Occupation:	Referred by: • Family • Friend • Insurance Plan	
Email:		

REASON FOR VISIT

• General Eye Exam	• Lost or Broken Glasses	• Watery Eyes	• Flashes or Floaters
• Contact Lens Exam	• Blurred Distance Vision	• Itchy Eyes	• Headaches
• Medical Visit	• Blurred Near Vision	• Dry Eyes	• Other

SOCIAL HISTORY

Smoking Status:		Do you drink Alcohol? : • Yes • No
• Current every day smoker	• Never smoker	Drug Use: • Yes • No
• Current some day smoker	• Former smoker	Caffeinated Beverages? • Yes • No

INSURANCE INFORMATION

(Only complete if you are **NOT** the primary insured patient)

Primary Insured Last name: First: MI:	DOB: / /
Social Security no.:	Relationship to Insured: •Spouse • Child •Other:	Phone Number: •Cell •Home ( )
Street Address(if different):		
City:	State:	ZIP Code:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practitioner. I understand that I am financially responsible for any balance. I also authorize Anthony B. Kouchak O.D. or insurance company to release any information required to process my claims.

Patient/Guardian Signature: Date: