WELCOME TO OUR OFFICE

ACADEMY CONTACT LENS CLINIC
John M. Cavanagh, O.D.
and Associates

Date____________________

Last Name_______________ First Name_______________ M.I.______
By what name would you like to be addressed? ___________________
Patient Date of Birth_____________

Address____
City________________________ State________ Zip Code__________
Home Phone (_____)___________ Work Phone (_____)_____________
Cell Phone (_____)_____________ E-mail _______________________
If under 18, parent/ guardian name(s)__________________________

Employer_______________________Occupation________________
If student, school name_______________________________________
Emergency Contact _____________________Phone (___)__________
Relationship to patient_______________________________________

Payment Policy: PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
Insurance information must be presented at time of service.

Referred by____

WE APPRECIATE HAVING THE OPPORTUNITY TO PROVIDE YOUR VISUAL HEALTH CARE TODAY. IF WE CAN BE OF SERVICE TO YOUR FAMILY AND FRIENDS, YOUR REFERRAL IS MOST WELCOME.