

TESCHER EYE CENTER

Family Owned Since 1959

Welcome to our office, your confidence in us is greatly appreciated.

Mr./Mrs./Ms./Dr. Last _____ First _____

Home Address _____

City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Daytime _____

Social Security # _____ Birthdate _____ Email _____

Whom can the Tescher Eye Center thank for your referral? _____

Do you currently wear eyeglasses? Y N Do you currently wear contact lenses? Y N

If you currently wear eyeglasses, are there certain times when you would rather not?
(for example-sports, business presentations, social occasion, etc.) Y N

List any sports or hobbies that you participate in _____

I request that payment for my services by my insurance company be made on my behalf to the Tescher Eye Center for covered services provided. I authorize this office to use and/or disclose optometric and medical findings per patient request or for insurance processing. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by Federal Privacy Regulations. I understand that I may, at any time, revoke this authorization by notifying, in writing, Dr. Tescher. However, a revocation will not affect any actions taken by the office prior to receipt of the revocation.

Patient/Guardian Signature _____ Date _____