Welcome to Drs. Babington and Babington, Optometrists

□ **Dr**. □ **Mr**. □ **Mrs**. □ **Ms**. □ **Miss** □ **Other**_____ **Sex**: □ **Male** / □ **Female** (as shown on insurance)

Date of Birth ____/____/____

Last Name _____ **First Name** _____ **MI**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Mobile #_____ **Work#**_____ **Home#**_____

Employer_____**Occupation**_____

Social Security Number_____-_____-_____ **Email**_____

Vision Insurance: □ **None** □ **VSP**(Vision Service Plan) □ **Davis** □ **EyeMed** □ **Spectera** □ **SVS** (Superior Vision Service)

Member_____ Relation_____ DOB_____ ID/SSN_____

I authorize Drs. Babington and Babington to release my personal health information (example: Glasses or Contact Lens Rx, billing information, dispensing of physical glasses or contacts) to the following individuals.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Acknowledgment and Consent: by submitting this form electronically you agree to and understand authorization by "Electronic Signature".

Send form via email >> info@drbabington.com