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_____

Patient Signature:_____ Date:_____

Or Name and Signature of Guardian & Relationship _____