

# Carrboro Family Vision

Matthew Vizithum, OD

Jason Chow, OD

Name : \_\_\_\_\_, \_\_\_\_\_  
Last First MI

(parent/guardian if minor) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_

Day Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Do you wear contacts? Yes / No Interested? Yes / No

Whom may we thank for referring you to us? \_\_\_\_\_

If it was a Friend/Family member, please give us their name. \_\_\_\_\_

If not a personal reference: Yellow Pages Ad / Bus Ad / Internet / Insurance

Who is Responsible for Paying This Account?

\_\_\_\_\_

Preferred Payment? Cash / Check / Credit

Insurance? Yes / No Company Name: \_\_\_\_\_

Relationship to Insured: Self / Spouse / Child