Angela Tsai, O.D., F.V.A.O.
Samuel C. Smart, O.D., F.V.A.O., F.A.A.O.
Bradley Church, O.D., F.V.A.O.

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230 Butler Road, Fredericksburg, VA 22405
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Phone: 540.373.3021 Fax: 540.373.5565

SCHEDULING FORM

Welcome to Premier Eyecare, Angela Tsai, O.D. and Associates, P.C., the office of Drs. Angela Tsai, Samuel Smart, and Bradley Church!

Please fill out the following information for your upcoming eye examination. All areas are required and must be filled out. We will call you within 24 hours after receiving your information to complete your appointment scheduling. We urge you to provide a mobile phone number for notifications and reminders. Please complete the entire form. There are 4 parts to fill out. You will be done when it says "FINISHED."
Bring your photo ID, insurance card, driver's license, and form of payment to your appointment. Missed appointments or those cancelled within 24 hours of the scheduled time will be assessed a $25 fee.

The doctors of Premier Eyecare recommend the Optomap, a digital picture to assess ocular health of the back of the eye. If you choose to forego the Optomap, please bring sunglasses with you since the effects of dilation include glare, blurry vision, and increased sensitivity to light.

Contact lens wearers should bring the current prescription or box of contact lenses with them as well as their eyeglasses, contact lens solution, and storage case. You will not be able to put contact lenses back on the eyes for a few hours if you choose to dilate.

We are happy to make additional appointments for family members. Comprehensive eye exams are recommended for age 6 months-1 year, 3 years, 5 years, and yearly after. We thank you for choosing us to provide all your eyecare needs and services. We look forward to seeing you and your family very soon!

PLEASE EMAIL THIS FORM BACK TO
FRONTDESKPREMEYECARE@GMAIL.COM
OR FAX AT 540-373-5565
AS SOON AS POSSIBLE.

PART 1

ABOUT THE PATIENT:

SALUTATION: Dr. Mr. Mrs. Ms. Miss Master [ ]New [ ] Existing patient

LAST________________________________FIRST ______________________ M___
PREFERRED/NICKNAME____
DATE OF BIRTH (MM/DD/YYYY)______/_______/_________
SOCIAL SECURITY NUMBER: ______ - ______ - ______

ADDRESS____
CITY____ STATE_____
ZIP____________

HOME PHONE (___)____-_______ DAYTIME PHONE (____)____-______
CELL PHONE (___)____-_______ [ ] OK TEXTING (Carrier charges may apply)
EMAIL____@______________________

COMMUNICATION PREFERRENCE (SELECT ONE):
[ ] MOBILE [ ] HOME PH. [ ] EMAIL [ ] PAPER

EMPLOYER____
OCCUPATION____

PREFERRED LANGUAGE [ ] ENGLISH [ ]OTHER________________

ETHNICITY _______________________ RACE___________________________

PART 2

ABOUT THE GUARANTOR: The guarantor is the parent or LEGAL guardian of the patient. The guarantor is the person who will be signing the Payment Agreement.

[ ] CHECK HERE IF THE GUARANTOR AND THE PATIENT ARE THE SAME. IF THEY ARE NOT, PLEASE FILL IN SPACES BELOW.

SALUTATION: Dr. Mr. Mrs. Ms. Miss

LAST___________________________________FIRST __________________ M___
DATE OF BIRTH (MM/DD/YYYY)_____/______/_________
SOCIAL SECURITY NUMBER: ______ - ______ - ______

ADDRESS____
CITY____________________________________ STATE_______ ZIP____________

PHONE (______)_______-___________

Patient Name_________________________

PART 3

[ ] I HAVE VISION INSURANCE
[ ] I HAVE MEDICAL INSURANCE

PLEASE PROVIDE BOTH YOUR VISION AND MEDICAL INSURANCE INFORMATION.

VISION INSURANCE:
INSURANCE NAME____

INSURANCE ADDRESS____

CITY____STATE_______ZIP_______________

VISION INSURANCE PHONE (________)___________-____________

INSURED PARTY'S NAME____

INSURED PARTY'S ID #_______________________________________

INSURED PARTY'S GROUP #__________________________________

RELATIONSHIP TO PATIENT__________________________________

MEDICAL INSURANCE:
INSURANCE NAME____

INSURANCE ADDRESS____

CITY____STATE_______ZIP________

VISION INSURANCE PHONE (________)___________-____________

INSURED PARTY'S NAME___________ _______________________________________

INSURED PARTY'S ID #_______________________________________

INSURED PARTY'S GROUP #__________________________________

RELATIONSHIP TO PATIENT__________________________________

Patient Name________________________

PART 4

I WOULD LIKE AN APPOINTMENT WITH/FOR: (CHECK ALL THAT APPLY)

[ ] DR. CHURCH [ ] DR. SMART [ ] DR. TSAI [ ] DOES NOT MATTER

[ ] MONDAY [ ] TUESDAY [ ] WEDNESDAY [ ] THURSDAY [ ] FRIDAY

[ ] 8:00-10:00 [ ] 10:00-12:00 [ ] 12:30-2:30 [ ] 2:30-4:40

[ ] 4:30-6:00 (THURS ONLY)

[ ] GLASSES [ ] CONTACT LENSES [ ] OCULAR HEALTH

[ ] REFRACTIVE SURGERY [ ] VISUAL THERAPY

I HAVE THE FOLLOWING OR AM CONCERNED ABOUT:
[ ] AMD [ ] CATARACTS [ ] DIABETES [ ] DRY EYE [ ] GLAUCOMA

[ ] LAZY EYE [ ] LEARNING-RELATED VISION ISSUES

[ ] OTHER____________________________________

SPECIAL REQUESTS/OTHER FAMILY MEMBERS NEEDING APPOINTMENTS____
____
____

(FINISHED)