



ALPINE VISION CENTER

BRIAN W. WOOD, OD
8585 W. 14th Ave., Suite C
Lakewood, CO 80215
Telephone: 303-238-4357
Fax: 303-238-4358

Patient's Name: Miss/Mrs./Mr. _____

Name of Head of Household _____

Address _____ Social Security # _____

City _____ State _____ Zip _____

Patient's Date of Birth _____ Age _____ Home Phone _____

Patient's Occupation _____ Work Phone _____

Employer/School _____ Grade _____

Other family members. If they have been a patient of ours, please put a check in the box by their name:

If married, name of spouse _____

Name of Children _____ Ages _____

How were you referred to us? Please check and fill in blank.

Person's Name _____ Doctor/Optician's Name _____

Yellow Pages _____

Direct Mail: Subject of mailing _____ Other _____

Have you ever worn glasses? Yes No If so, are your eyeglasses bothersome to you? Yes No

Have you ever worn contact lenses? Yes No If so, what type of lenses _____

If you are wearing contact lenses, who fitted you originally?

(Name & Address) _____

Are you interested in being fitted for contact lenses? Yes No

Please check your preferred method of payment:

Cash Check Visa/Mastercard

Please check one if it applies to you:

Medicare Medicaid (The Card) HMO-PPO Insurance

FEES DUE UPON SERVICES RENDERED

THANK YOU!