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Name _____
First MI Last Nickname

If a child, parent/guardian's name: _____

Birthday: _____ SSN _____ M [] F []

Address: _____
Street City State Zip

Home Phone: (____) _____ Day Time Phone: (____) _____

Cell Phone: (____) _____ Email Address: _____
Texting OK? [] Yes [] No

*Communication Preference: [] home phone [] cell phone [] email [] mail

Occupation/Employer: _____

Health Insurance: _____
Plan ID# Policy/Group #

Member's Name Member's Date of Birth Relationship to member

How did you hear about our office? _____

PLEASE NOTE *** All Returned Checks Are Subject To A \$25 Service Fee***

I authorize release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____