



Welcome To Our Office
ADVANCED EYE CARE CENTER
Dr. George K. Johnson
Optometrist

Date _____

Patients Name _____ DOB _____

Address _____

City _____ State _____ Zip _____ Social Sec# _____

Home Phone _____ Work _____ Ext _____

Employer _____ Occupation _____

Medical Insurance _____ [] **PPO** or [] **HMO**

Primary Insured Name _____ DOB _____

ID# _____ **Relation to Patient:** Self, spouse, parent, other

Who may we **Thank** for your referral _____

We invite you to participate in our online system. Features include:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

If ok please initial _____ **Communication Pref:** Telephone, Email, Text

Cell _____ Email _____

ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE

I authorize payment of my benefits directly to **Advanced Eye Care Center** for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand that some services and procedures may not be covered by my insurance carrier. Fees not paid by my insurance carrier will be my responsibility.

This authorization is in effect until I choose to revoke it.

Signed _____ Date _____

I Acknowledge I have been offered/received a copy of this office's Notice of Privacy Practice.

Signed _____ Date _____