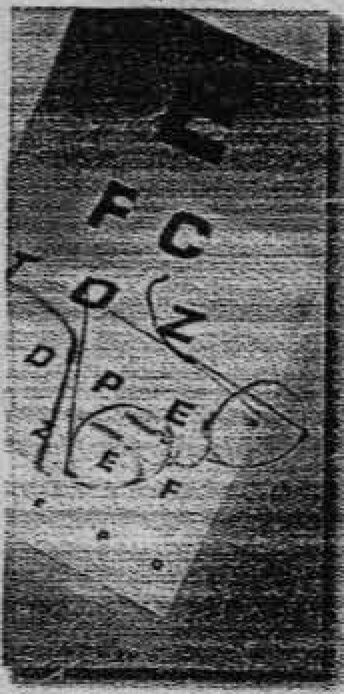

Welcome

CLEAR VISION BEGINS WITH HEALTHY EYES

Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name ______________________ Date __________ Patient No. __________
First MI Last
Address ______________________ City __________ State _____ Zip __________
Birthdate __________ Home phone # __________ Work phone # __________
Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Either
Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated
Your or your parent's employer ______________________ Occupation __________
Business Address ______________________ City __________ State _____ Zip __________
Spouse's or parent's name __________ Workplace __________ Work phone # __________
If you are a student, name of school/college __________ City __________ State _____
Whom may we thank for referring you to us? ______________________
Person to contact in case of emergency ______________________ Phone # __________
Email address: __________

Responsible Party

Name of person responsible for this account? ______________________
Relationship to patient __________ Phone # __________
Address ______________________ City __________ State _____ Zip __________
Name of employer ______________________ Work phone # __________

Insurance Information

Name of insured ______________________ Relationship to patient __________
Birthdate __________ Social Security # __________ Date employed __________
Name of employer ______________________ Work phone # __________
Address ______________________ City __________ State _____ Zip __________
Insurance Co. ______________________ Group # __________ Employer # __________
Insurance Co. Address ______________________ City __________ State _____ Zip __________
How much is your deductible? __________ How much have you used? __________ Max. annual benefit? __________
DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of insured ______________________ Relationship to patient __________
Birthdate __________ Social Security # __________ Date employed __________
Name of employer ______________________ Work phone # __________
Address ______________________ City __________ State _____ Zip __________
Insurance Co. ______________________ Group # __________ Employer # __________
Insurance Co. Address ______________________ City __________ State _____ Zip __________
How much is your deductible? __________ How much have you used? __________ Max. annual benefit? __________

Patient Name:______________________________

SSN#:______________ Birth State:__________

Ethnicity:______________ Race:_____________

Mother's Maiden Name:___________________

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____

SIGNATURE OF PATIENT (Or parent if a minor) DATE

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