**Name:** _____, _____ _____
Last First Middle Int.

**Address:** _____ _____
Street Apt/Unit/Floor

_____ _____ _____ **Primary Phone Number:** (_____) _____ - _____ Cell/Home
City State Zip Code

**Date of Birth:** _____ /_____ /_____ **S.S #** (*Needed for Insurance billing*) _____ - _____ - _____

**Email Address:** _____

**Sex:** M☐ F☐ **Marital Status:** S☐ M☐ D☐ W☐ **Spouse's Name:** _____
(IF APPLICABLE)

**If under 18 Mother/Father's Name:** _____

**Employer/Occupation:** _____

**Primary Care Physician:** _____ **Preferred Pharmacy:** _____

**Emergency Contact/POA:** _____ _____
Name Relationship

**Contact Number:** (_____) _____ - _____ **Can discuss your care with this person**: YES / NO

## ***INSURANCE INFORMATION***

***Vision Insurance*** : AVESIS☐ BAI☐ EYEMED☐ SUPERIOR☐ VBA☐ VSP☐ OTHER:_____

*Policy Holder*: SELF☐ SPOUSE☐ PARENT☐

Name (other than SELF): _____ DOB:_____ / _____ / _____ Last 4 S.S #: _____

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***PRIMARY Medical Insurance***: AETNA☐ CIGNA☐ HIGHMARK☐ HUMANA☐ MEDICARE☐ TRICARE☐ UHC☐ UPMC☐
OTHER:_____

*Policy Holder Name* (other than SELF): _____

Relation: SELF☐SPOUSE☐PARENT☐ DOB:_____ / _____ / _____ S.S # _____ - _____ - _____

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*****IF YOU HAVE A SECONDARY INSURANCE AND WOULD LIKE IT BILLED AFTER THE PRIMARY, PLEASE ENSURE THAT THE*****
***PROPER INFORMATION IS FILLED OUT COMPLETELY***

***SECONDARY Medical Insurance***: AETNA☐ CIGNA☐ HIGHMARK☐ HUMANA☐ MEDICARE☐ TRICARE☐ UHC☐ UPMC☐
OTHER:_____

*Policy Holder Name* (other than SELF) _____

Relation: SELF☐SPOUSE☐PARENT☐ DOB:_____ / _____ / _____ S.S # _____ - _____ - _____

**PATIENT'S INSURANCE AUTHORIZATION/SIGNATURE ON FILE:**

I request that payment of authorized insurance benefits be made to either me or on my behalf to Bayfront Eyecare for any services furnished for me/my dependent by the physician/supplier. I authorize any holder of hospital or medical information about me/my dependent to be released to the above named insurance company(s) and its agents, any information needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible for payment of me/my dependent's account.

_____ _____
Insured's Signature Date