## PATIENT INFORMATION

PATIENT NAME:_____
(Last) (First) (MI

ADDRESS: _____
(Street/PO Box) (Apt #)

_____
(City) (State) (Zip)

PHONE NUMBER: _____ SECONDARY PH #: _____ PATIENT SEX ( ) MALE ( ) FEMALE

EMAIL: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____SOCIAL SECURTY NO:_____

EMPLOYER: _____ ( ) FULL-TIME ( ) PART-TIME

OCCUPATION: _____ BUSINESS PHONE: _____

RACE: _____ ETHNICITY: ( )Decline ( ) Hispanic or Latino
( )Not Hispanic or Latino
PREFERRED LANGUAGE: _____ ( )Native Hawaiian/other Pacific Islander

PERSON TO NOTIFY IN AN EMERGENCY: _____
(Name) (Phone)

## INSURANCE POLICY HOLDER INFORMATION

***PLEASE FILL OUT COMPLETELY, IF PATIENT IS NOT THE POLICY HOLDER***

INSURED'S NAME: _____ DATE OF BIRTH: _____

ADDRESS:_____ CITY/STATE/ZIP:_____

LAST FOUR NO. SOCIAL SECURITY :_____ SEX: ( ) MALE ( ) FEMALE

EMPLOYER NAME/ADDRESS: _____

_____BUSINESS PHONE:_____

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

SECONDARY INSURANCE COMPANY: _____

Does your insurance cover a routine eye exam? _____ Name of Vision Insurance: _____

**PLEASE BE ADVISED: INSURANCE CLAIMS ARE FILED AS A COURTESY FOR OUR PATIENTS. IT IS YOUR RESPONSIBILITY TO KNOW THE SPECIFICS OF YOUR PLAN. PLEASE CONTACT YOUR INSURANCE COMPANY PRIOR TO YOUR VISIT TO VERIFY THAT THE PHYSICIAN IS A PARTICIPATING PROVIDER, CHECK REFERRAL STATUS (IF REQUIRED), AND CHECK COPAY/DEDUCTIBLE/CO-INSURANCE REQUIREMENTS REQUIRED FOR YOUR VISIT.**

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any noncovered services or unpaid balance and any legal fees necessary to collect the unpaid balance. I also authorize my physician to release any information required in processing these benefits.

PATIENT/GUARDIAN SIGNATURE: _____DATE:_____

**REFERRED BY: ( ) PHYSICIAN_____ ( ) OTHER_____**