PATIENT INFORMATION

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

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

_____
(City) (State) (Zip)

HOME PHONE: _____ CELL PHONE: _____

PATIENT SEX: ( ) MALE ( ) FEMALE DATE OF BIRTH: _____ AGE: _____

MARITAL STATUS: _____ SOCIAL SECURTY NO:_____

EMPLOYER: _____E-MAIL_____

OCCUPATION: _____ BUSINESS PHONE: _____

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 THE PHYSICIAN IS A PARTICIPATING PROVIDER, CHECK REFERRAL STATUS (IF REQUIRED), OR IF YOU HAVE MET ANY ANNUAL DEDUCTIBLES.

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 SIGNATURE: _____DATE: _____

REFERRED BY: ( ) PHYSICIAN_____ ( ) OTHER_____

FORM OF PAYMENT/ CREDIT CARD_____ CASH____ **WE DO NOT ACCEPT CHECKS**