Welcome to Our Office!

Thank you for choosing our practice for your eye care. Please take a few minutes to answer the following questions so that we may better assist you with your eye health care needs.

Patient Information

Name_____ Birth date_____/_____/_____ Birth State_____
(first) (middle) (last)

SSN_____ Male / Female Home #_____ Cell #_____

Address _____ PO Box _____ City _____

State _____ Zip _____ Email _____ Contact preference: Cell / Home / Email

Occupation _____ Employer _____ Work # _____

Marital Status _____ Race _____ Ethnicity: Hispanic / Not Hispanic Preferred Language _____

How did you hear of us? _____ Mother's maiden name _____

Emergency contact _____ Ph # _____

Insurance Information

Primary Person Responsible for Account _____ Relationship to patient _____

Address (if different) _____ Employed by _____

Vision Ins Co. _____ ID #_____SSN _____Birth date ___/____/____

Medical Ins Co. _____ ID #_____ Group # _____

Second Person Responsible for Account _____ Relationship to patient _____ _____

Address (if different) _____ Employed by _____

Vision Ins Co. _____ ID#_____ SSN _____ Birthdate ___/____/____

Medical Ins Co. _____ ID #_____ Group # _____

Privacy Practices Acknowledgement

I have received the **Notice of Privacy Practices**, and I have been provided an opportunity to review it.

Name of Patient _____ Birthdate _____

Signature _____Relationship to patient (if signed by patient representative) _____

I certify that the above information is correct, and I understand that I am legally responsible for payment of all charges, whether or not paid by insurance. I will by responsible for any co-payments, deductibles or non-covered items at the time service are rendered. I authorize the doctor to release all information necessary to secure the payment of benefits. I have read this information, and I am the patient, the patient's guarantor or authorized to execute this agreement and accept its terms.

Signature _____ Date _____