Welcome to . Thank you for choosing us for your eyecare and eyewear needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address _____ Spouse or Parent(s) Name _____

Person Financially Responsible, If Different than Above

Name:_____ Phone:_____

Address_____ Soc. Sec #_____

_____ Birthdate _____

Place & Address of Employment_____

Work Phone # ( )_____

	ft	in	cm/m	
Height				○ ft in ○ cm ○ m
Weight				○ lbs ○ kg

Race

☐ American Indian Or Alaska Native
☐ Asian
☐ Black Or African America
☐ Hispanic Or Latino
☐ Native Hawaiian Or Other Pacific Islande
☐ White
☐ Declined To Specify

Other Race _____

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemis ○ French ○ Germa ○ Hindi ○ Indo

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) _____

☐ Insurance Listing ☐ Drive by ☐ Other _____ ☐ Doctor (Please Name) _____

Patient has received HIPAA Privacy Policy? ○ Yes ○ No **Date** _____

Notes _____

Name

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

We require that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from an insurance company is to be paid directly to the subscriber. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature | Date