

Today's Date _____

PLEASE PRINT CLEARLY

PERSONAL INFORMATION

Patient Name Last First MI Social Security No.

Date of Birth Sex Marital Status Race

M F S M D W

Patient Address Street City State Zip Code

Patient Email

Referring Doctor Address Medical Doctor (if other than referring doctor) Address

Person Responsible for Payment Address (if other than patient address)

Contact in Case of Emergency Name Relationship to Patient Telephone Number

Responsible Party Telephone Number Cell Phone Number Work Telephone Number

Patient Telephone Number Cell Phone Number Work Telephone Number

Regardless of the insurance coverage or workers' compensation coverage I have, I agree I am ultimately responsible for the bill. If my account requires collection service, I realize I will be responsible for any collection costs.

Signature Date

INSURANCE INFORMATION

Please present your health insurance cards so we can make a copy for our records.

Vision Insurance Co. Medical Insurance Co.

Subscriber's Name Subscriber's Sex Relationship to Patient

Subscriber's Birthdate Subscriber's Social Security Number

Subscriber's Employer Employer's Telephone Number

ID # Group/Account #

If you have no health insurance check here _____

PLEASE TELL US HOW YOU HEARD ABOUT OUR PRACTICE

- _____ Family doctor (Dr. _____) referred me. (2)
- _____ Another eye doctor (Dr. _____) referred me.(2)
- _____ Internet (4)
- _____ Hospital (6)
- _____ Yellow Pages (1)
- _____ Friend or relative (3)
- _____ Insurance company (5)
- _____ Newspaper (7)
- _____ Other (8) _____