



Thank you for choosing our practice for your eye care needs. If you have any questions filling out this form, please ask for assistance. (Please Print)

PATIENT INFORMATION

FIRST NAME:

LAST NAME:

MIDDLE INITIAL:

SALUTATION:

GENDER:

SOCIAL SEC. #:

BIRTH DATE:

AGE:

ADDRESS:

CITY:

STATE:

ZIP:

HOME PH:

WORK PH: Ext:

EMPLOYER:

OCCUPATION:

HOBBIES/INTERESTS:

RESPONSIBLE PARTY

PERSON RESP. FOR ACCOUNT: Self/Other

If other, who:

RELATIONSHIP TO PATIENT:

↓ FILL IN FOLLOWING IF OTHER THAN SELF ↓

HOME PH:

WORK PH:

ADDRESS:

CITY:

STATE:

ZIP:

INSURANCE INFORMATION

NAME OF INSURED:

INSURED ID#/SS#:

INSURED BIRTH DATE:

PT. RELATIONSHIP TO INSURED:

INSURANCE CO.:

GROUP #:

EMPLOYER:

INSURED IS: Minor/Married/Divorced/
Widowed/Single/Separated

ADDITIONAL INSURANCE: Yes/No

↓ IF YES PLEASE FILL IN THE FOLLOWING ↓

NAME OF INSURED:

INSURED ID#/SS#:

EMPLOYER:

WORK PH:

INSURANCE CO:

GROUP #

INSURANCE AUTHORIZATION

I authorize and request my insurance company to pay directly to the optometrist or optometric group insurance benefits otherwise payable to me. I understand that my insurance carrier may deny or may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

SIGNATURE:

DATE:

REFERRAL

Who referred you to our office?

Friend or Family Member:

Phonebook/Insurance Co./Website/Other: