

WELCOME TO THE EYE CLINIC AND CONTACT LENS CENTER:

Thank you for taking the time to fill out these forms. It allows us to better care for your needs and comply with current insurance, finance and HIPAA laws.

PATIENT INFORMATION: Patient Name: _____
ID/SS# _____ - _____ - _____ Birth date: ____/____/____ Age: _____ Male Female
Home Phone:(____) _____ - _____ Alternate Phone:(____) _____ - _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employer _____
Business Address: _____ City: _____ State: _____ Zip: _____
Business Phone:(____) _____ - _____
Marital Status: Single Married Divorced Separated Widow
e-mail address: _____

Responsible Party: Please select applicable: Spouse Parent
Name: _____
ID/SS# _____ - _____ - _____ Birth date: ____/____/____ Age: _____ Male Female
Home Phone:(____) _____ - _____ Alternate Phone:(____) _____ - _____
Address: _____ City: _____ State: _____ Zip: _____
Occupation: _____ Employer _____
Business Address: _____ City: _____ State: _____ Zip: _____
Business Phone:(____) _____ - _____
Marital Status: Single Married Divorced Separated Widow

REFERRED BY: Name: _____
Home Phone:(____) _____ - _____ Alternate Phone:(____) _____ - _____
Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: Is This Group Insurance? ____ If Yes, Who Is Your Employer? ____
Name Of Insurance Co: _____ Phone:(____) _____ - _____
Address of Insurance Co: _____ City: _____ State: _____ Zip: _____
Policy Holder: _____ ID/ SS# _____ - _____ - _____ Birth date: ____/____/____
Relationship To Patient: _____ Policy Holder's Phone:(____) _____ - _____
Policy Holder's Address: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Group Number: _____ Co-payment Amount:\$ _____

SECONDARY INSURANCE: Is This Group Insurance? ____ If Yes, Who Is Your Employer? ____
Name Of Insurance Co: _____ Phone:(____) _____ - _____
Address of Insurance Co: _____ City: _____ State: _____ Zip: _____
Policy Holder: _____ ID/ SS# _____ - _____ - _____ Birth date: ____/____/____
Relationship To Patient: _____ Policy Holder's Phone:(____) _____ - _____
Policy Holder's Address: _____ City: _____ State: _____ Zip: _____
Policy Number: _____ Group Number: _____ Co-payment Amount:\$ _____

CONTACT IN EMERGENCY: (someone not living with you)
Name: _____ Phone:(____) _____ - _____
Relationship: _____ Address: _____
I certify that the above information is correct.
Signature _____ Patient (or Parent/Guardian if patient is a minor) _____ Date: _____