PATIENT INFORMATION

Patient's Legal Name:_____

Preferred Name:_____

Patient's
Date of Birth:_____/_____/_____ Patient's Social Security No.:_____

Street Address:_____

City:_____State:_____Zip:_____

Name of Spouse or Legal Guardian:_____Date Of Birth:_____
(***For insurance purposes only)***
Spouse/Legal Guardian Social Security No.:_____
(For insurance purposes only)

CONTACT INFORMATION

Home No.:_____ Work No:_____

Cell No.:_____ E-Mail Address:_____

Occupation:_____

Employer Name:_____ Address:_____

City:_____State:_____Zip:_____

INSURANCE INFORMATION

Name of Medical Insurance:_____

Member ID:_____ Policy Holder Name:_____

Name of Vision Insurance:_____

Member ID:_____Policy Holder Name:_____

Primary Care Physician's Name:_____

Referral Information—How did you learn about office?_____

If you were referred by a current patient, whom may we thank?_____

This is a legally binding contract for fees. Professional services, glasses, or contact lenses are to be paid upon services rendered. All other payment arrangements must be made in advance. Thank You! Unpaid insurance is the responsibility of the patient/bill payer and will be billed accordingly at 90 days.

Patient's Signature/Legal Guardian_____Date_____