



DATE: _____

APPOINTMENT: _____

PT. # _____

Please complete all areas below.

DR. _____

PATIENT INFORMATION

TITLE _____ LAST _____ FIRST _____ MI _____

MR. MRS. MS. _____

ADDRESS _____ CITY, STATE, ZIP _____

HOME PHONE (____) _____ BUSINESS PHONE (____) _____

CELL PHONE (____) _____ PAGER _____ E-MAIL _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE: _____ SEX: M F

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY, STATE, ZIP _____

NEXT OF KIN (Other Than Spouse) _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

RETIREMENT DATE: _____ IS YOUR SPOUSE EMPLOYED? Yes No

HOW DID YOU HEAR ABOUT EYECARE? _____

MEDICAL INSURANCE INFORMATION

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARDS TO BE KEPT ON FILE.

FINANCIALLY RESPONSIBLE PARTY: IF DIFFERENT FROM ABOVE

TITLE _____ LAST _____ FIRST _____ MI _____

MR. MRS. MS. _____

ADDRESS _____ CITY, STATE, ZIP _____

SOCIAL SECURITY # _____ EMPLOYER _____

HOME PHONE (____) _____ BUSINESS PHONE (____) _____

CELL PHONE (____) _____ PAGER _____ E-MAIL _____

ACKNOWLEDGMENT: I have reviewed the above and verify that it is correct. I understand all charges are due and payable in full at the time of service and I will abide by this policy. For services such as surgery, etc., or if I have MEDICARE, I authorize any or all insurance companies to pay benefits directly to the doctor unless I have paid them myself; then the benefits would come to me. I also authorize the release of medical information necessary in handling my claims.

Federal law suggests your physician disclose to you any ownership interest your physician may have in an entity you are referred to for further services. If you would like more information about your physician's ownership interest, please discuss this with your physician.

SIGNATURE: _____ DATE: _____

Notice of Privacy Practices Acknowledgement Form

I have been provided with and read a copy of Eyecare Associates's Notice of Privacy Practices.

Signature of Patient or Personal Representative _____ Date _____

Print Name of Patient or Personal Representative _____ Description of Personal Representative's Authority _____