EYECARE ASSOCIATES

Please complete all areas below.

PATIENT INFORMATION

TITLE FIRST MI LAST Suffix (JR, SR)

MR .☐ MRS.☐ MS.☐ _____ DOB_____SEX: M ☐ F☐

ADDRESS _____ APT. # CITY, STATE, ZIP _____

HOME PHONE ( ) _____BUSINESS PHONE (__) _____

CELL PHONE (_____) _____ E-MAIL _____

SOCIAL SECURITY#_____

LANGUAGE ☐ ENGLISH ☐ SPANISH ☐ OTHER_____

OCCUPATION_____ EMPLOYER _____

ADDRESS_____CITY, STATE, ZIP_____

OTHER CONTACT NAME_____ RELATIONSHIP_____

HOME PHONE _____

RACE

☐ American Indian or Alaskan Native ☐ Black

☐ Asian or Pacific Islander ☐ White

ETHNICITY

☐ Hispanic Origin

☐ Not of Hispanic Origin

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

TITLE LAST FIRST MI

MR.☐ MRS.☐ MS.☐ _____

ADDRESS _____ CITY, STATE, ZIP _____

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

ACKNOWLEDGEMENT: 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.

SIGNATURE: _____DATE: _____

Notice of Privacy Practices Acknowledgement Form

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

_____ _____

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

_____

Signature of Patient or Personal Representative Date