Welcome!

Thank you for choosing our practice for your eye care needs.

Date:	Referred By:

Patient Information:

First Name:	Middle Name:	Last Name:	
Mailing Address:	City:	State:	Zip Code:
Home Telephone:	Work Telephone:	Employer:	
SSN:	DoB:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single ☐ Other

Responsible Party Information: ☐ Check box if the same as above.

First Name:	Middle Name:	Last Name:	
Mailing Address:	City:	State:	Zip Code:
Home Telephone:	Work Telephone:		
SSN:	Employer:		

Please list family members (living in the same household) below and indicate if they are patients in our office.

Name:	☐ Yes ☐ No	Name:	☐ Yes ☐ No
Name:	☐ Yes ☐ No	Name:	☐ Yes ☐ No

Insurance Information:

1. Vision Insurance Carrier Name:	Employer Name:	
Policy Holder Name:		DoB:
Policy ID Number:	Group Number:	Relationship to Patient:
2. Medical Insurance Carrier Name:	Employer Name:	
Policy Holder Name:		DoB:
Policy ID Number:	Group Number:	Relationship to Patient:
3. Additional Insurance Carrier Name:	Employer Name:	
Policy Holder Name:		DoB:
Policy ID Number:	Group Number:	Relationship to Patient:

Read carefully, sign and date: I understand that all fees are due and payable at the time of service unless other arrangements have been made and agreed upon. A deposit of _ of the material cost is collected before materials will be ordered. As a courtesy to me, the patient, this office will file insurance claims for payment in accordance with the information I have provided. I am responsible to provide proof of insurance, accurate and complete patient and billing information, and for obtaining proper referrals and preauthorization, in accordance to the provision of my vision or health care plan, for all services/procedures rendered to me by my physician.

I understand and request that payment of authorized Medicare/other insurance company benefits be made directly to EyeCare Associates on my behalf for all services/procedures rendered. I authorized any holder of medical information about me to release any pertinent information needed to determine these benefits or the benefits payable to related services/procedures. I understand and agree that if my physician agrees to accept the determination of the insurance company as full payment, then I am only responsible for co-pay, co-insurance, deductible and non-covered service/procedure amounts. I agree to pay my portion(s) due at time of service or immediately upon receipt of a statement from EyeCare Associates.

Signature _____ Date _____