Family Eye Care Patient Information Sheet

Name: _____ Date of Birth: _____ Sex: ☐M ☐F

__Married __Single __Divorced __Widowed **RACE** __White __Black __Hispanic __Asian __Other

Home Address: _____ City: _____ State:_____ Zip Code: _____

Home Number: _____ Cell Number: _____ Email: _____

Drivers License Number: _____ Social Security Number: _____

Employer: _____ Work Number: _____

Spouse | Parent Name _____ SS# _____ Date of Birth: _____

Spouse | Parent Employer: _____ Work Number: _____

In Case of Emergency Contact: _____ Phone Number: _____

Insurance Information:

Policy Holders Name: _____ Policy Holders DOB: _____ Policy Holders SS#:_____

Primary Insurance Name: _____ ID Number: _____ Phone #: _____

Policy Holder Address: _____ City_____ State _____ Zip_____

Policy Holder Place of Employment _____

Secondary Insurance Policy Holders Name: _____ Policy Holders DOB: _____

Policy Holders SS#:_____

Secondary Insurance: _____ ID Number: _____ Group Number: _____

Medicare Number: _____ Medicaid Number: _____

PLEASE BE SURE TO GIVE THE RECEPTIONIST YOUR INSURANCE CARD AND DRIVER'S LICENSE SO THAT WE MAY MAINTAIN A COPY IN YOUR CHART. Explanation of Practice Policy: Patients who carry any form of medical or surgical insurance should know that all services furnished are charged directly to the patient and that he or she is responsible for payment. We will help you prepare your primary forms to assist in the making of collections from your insurance company. However, **WE DO NOT RENDER SERVICES ON THE ASSUMPTION THAT YOUR CHARGES WILL BE PAID BY YOUR INSURANCE COMPANY.** This is a contract between you and / or your employer and the insurance company. **YOUR BILL WITH US IS YOUR RESPONSIBILITY.** All insurance forms processed by this office and any proceeds there form, prior to payment in full, are assigned to this practice and I authorize payment of vision and medical benefits directly to **Family Eye Care**, and / or **William D. Gordon O.D. I agree to be fully responsible for all lawful debts incurred by myself or my dependent child for services received from Family Eye Care, whether those services are covered by insurance or not.**

Patient or Guardian's Signature _____ Date: _____