

FAMILY EYECARE SPECIALISTS, PLLC

WELCOME TO OUR OFFICE

Thank you for choosing our office.

In order to serve you properly, please provide the following information. Print clearly and leave no blanks.

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

DOB ____/____/____ Marital Status: S M D W Dr. Lic# _____

SS Number _____ If patient is a child, who may authorize treatment? _____ Relationship? _____

Employer Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name: _____ Phone: (_____) _____

Do you have vision insurance? Yes No Do you have medical insurance? Yes No

If no, how will you be paying today? Cash Check Credit Card

Whom should we thank for referring you? _____

PRIMARY INSURANCE (Insurance companies require the below information for billing purposes.)

Name Of Insured: _____ Relationship to Pt: _____

Insured's Social Security # _____ - _____ - _____ Insured's DOB ____/____/____

Insurance Co. Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Policy #: _____ Group ID: _____

SECONDARY INSURANCE

Name Of Insured: _____ Relationship to Pt.: _____ DOB: ____/____/____

SS#: _____ - _____ - _____ Policy #: _____ Group #: _____

Insurance Co. Name: _____ Phone: (_____) _____

I authorize Family Eyecare Specialist to discuss medical and/or billing information with the following individual:

Name: _____ Relationship: _____

I authorize the release of any information concerning my (or my child's) healthcare, to expedite insurance payment. I also hereby authorize payment of insurance and understand that I am responsible for all charges, regardless of insurance coverage.

Signature of patient, parent, or legal guardian

Date