



Welcome

PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete this form and if you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please print)

Name _____ Date _____

First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home phone _____ Work phone _____

Cell phone _____ Email address _____

SS # _____ Marital Status _____ Employment Status _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Do you have vision insurance? _____ If yes, Ins. Co _____

Name of insured _____ Relationship to insured _____

ID# _____ Group# _____

Insured date of birth _____

Do you have medical insurance? _____ If yes, Ins. Co _____

Name of insured _____ Relationship to insured _____

ID# _____ Group# _____

Insured date of birth _____

Authorization

I authorize Eye1st Vision Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Eye1st Vision Center insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent if a minor)

Date