Welcome to . Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State Zip ______

Social Security Number ______ Date of Birth ______ Home Phone - Include Area Code ______ Work Phone ______

E-mail ______ Dr. ______ Patients Primary Doctor ______

	ft	in	cm/m	
Height				○ ft in ○ cm ○ m
Weight				○ lbs ○ kg

Race
- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African America
- ☐ Hispanic Or Latino
- ☐ Native Hawaiian Or Other Pacific Islande
- ☐ White
- ☐ Declined To Specify

Other Race ______

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi ○ In

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name) ______

☐ Insurance Listing ☐ Drive by ☐ Other ______ ☐ Doctor (Please Name) ______

Patient has received HIPAA Privacy Policy? ○ Yes ○ No **Date** ______

Notes ______

PRIMARY INSURANCE INFORMATION **HSA ACCOUNT Yes No**

Name and Address of Primary Insurance Company ______ City ______ State Zip ______

M ☐ F ☐ Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance may be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature ______________________ Date ______________________