WELCOME TO OUR OFFICE

By completing this patient information form, you will help us to serve you more efficiently. Should you have any questions concerning our professional services or office procedures, please ask.

PLEASE PRINT-COMPLETE ALL INFORMATION

PATIENT

Name_____Acct. #_____

Date of Birth_____/___/_____Age_____Social Security #_____

Home Address_____

City_____State_____Zip_____

Home Phone_____Cell/Pager_____

Employer_____

Occupation_____Work Phone_____

Business Address_____

SPOUSE

Name_____Cell/Pager_____

Social Security #_____Date of Birth_____

Employer_____Work Phone_____

EMERGENCY CONTACT

Name_____Phone_____

REFERRING PHYSICIAN_____

If we will be filing your claim with your insurance company, it will be necessary for you to bring your card with you to your appointment. Please bring with you ALL your medical insurance cards. Without copies of your cards, we may be unable to file your claims.

Primary Insurance_____Policy #_____

Policy Holder_____Group #_____

Mailing address for medical claims_____

Insurance Phone (Benefits/Customer Service)_____

AUTHORIZATION OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize payments for the medical and/or surgical benefits to be made directly to Children's Eye Care, PLLC. I understand I am responsible for any portion of my bill not covered by my insurance company. I also authorize release of information for insurance claim purposes.

Signature_____Date_____