NEW PATIENT INFORMATION PAGE 1

Today's Date: _____

Name: _____ Birthdate: _____ Sex: M F Age: _____

Address:_____

Street City State Zip

Race: □ White □ American Indian/ Alaska Native □ Asian □ Black/ African American □ Native Hawaiian/Pacific Islander □ Other

Preferred Language: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown

Social Security Number: _____ Preferred phone (circle): Cell Home Other

Cell Phone: (_____)_____ Home/Other Phone: (_____)_____

Employer: _____ REFERRED BY: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Family Doctor: _____

Nearest Relative/Friend (not in your household): _____

Relationship: _____ Phone: (_____)_____

PARENT/GUARDIAN/PERSON RESPONSIBLE FOR ACCOUNT: ☐ Same as above

Name: _____ Relationship to Patient: _____

Address:_____

Street City State Zip

Home Phone: (_____)_____ Work Phone: (_____)_____

Employer's Name & Address: _____

INSURANCE INFORMATION: (Please give insurance cards to receptionist for photocopying)

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Policy Holder's Social Security Number: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Policy Holder's Social Security Number: _____

OFFICE POLICY

Payment/copayment for office visit is expected at the time the service is rendered. Many insurance companies do NOT cover eye refractions (ie. Medicare, Medicaid). In addition, other office procedures & surgical procedures may not be covered by my insurance plan. By signing this, I understand that I am responsible for my account, even if a claim is filed with my insurance company. This office cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim. I will receive a monthly statement if my account has a balance due.

If collection proceedings are required, I agree to pay all collection costs, court costs, and reasonable attorney fees.

_____ _____

Signature Date