PLEASE PRINT

PATIENT INFORMATION

Date________________________

Patient Name____Birthdate__________Age______

Patient SS#____

Address:______________________________City/State__________________Zip__________

Phone: Home________________Work____________________Male________Female________

Employer (School)__________________________________Occupation (Grade)______________

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Person Responsible For Bill____

Please Note: Payment is requested when services are provided. Unless your insurance policy includes specific vision benefits, routine eye examinations are generally not covered unless you have a medical eye condition.

INSURANCE INFORMATION

Medicare #__________________________Medicare Supplement__________________________

Policy #____________________________Group #_______________________________________

Medical Insurance____

Policy #____________________________Group #_______________________________________

Insured's Name____

Insured's place of employment____

ADDITIONAL INFORMATION

____

____

____

Signature______________________________________

I understand that I am responsible for all services rendered regardless on insurance coverage.

____ ______________________

Signature of Patient or Authorized Representative Date