PRECISION EYE CARE

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PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Sex: M / F Social Security: _____-_____-_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Would you like to receive appointment reminder calls on your **HOME PHONE or CELL PHONE**?(CIRCLE ONE)

Email Address: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If Patient is a minor, Responsible Party: _____

INSURANCE INFORMATION

1. Primary Insurance: _____

Member ID # _____ Group # _____

Policy Holders Information: (if different than above)

Name: _____ Date of Birth: _____

Social Security: _____-_____-_____ Sex: M / F Relation: { }Spouse { }Parent { }Other

_____

2. Secondary Insurance: (if applies)_____

Member ID # _____ Group # _____

Policy Holders Information: (if different than above)

Name: _____ Date of Birth: _____

Social Security: _____-_____-_____ Sex: M / F Relation: { }Spouse { }Parent { }Other

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to my physician. I understand that I am financially responsible for any balance including deductibles, coinsurance, copayment, and/or non-covered services. I also authorize Precision Eye Care or my insurance company to release any information required to process claims.

Patient Signature: _____ Date: _____

(If a minor, Parent/Guardian)