The Eye Center

Patient Information

Name: Last	First	Middle	Today's Date:

Sexual Orientation:	Preferred Pronoun:	Gender Identity:	
Birth Date:	Age:	Race / Ethnicity / Language	
Address:	Apt.	Occupation:	
City:	State:	Zip:	Employer:
Phone #'s — Cell:	Home:	Work:	
Email:	Preferred Method to be contacted: ☐ Cell ☐ Work ☐ Home ☐ Email		

Emergency Contact:	Phone #:	Relationship to Patient:

PRIMARY Insurance:	*Patient is the policy subscriber/ guarantor:*
ID/Policy #:	☐ Yes ☐ No
SECONDARY Insurance:	☐ Yes ☐ No
ID/Policy #:	
VISION/OPTICAL Insurance:	☐ Yes ☐ No

If policy subscriber/ guarantor is other than the patient: Name:	Relationship to Patient:
Phone:	Birth Date:

Family/Primary Physician:	Phone:
Address:	

Do you want a routine vision/glasses examination?	☐ Yes ☐ No
Do you currently wear Contacts Lenses?	☐ Yes ☐ No
Do you want a Contact Lens Evaluation and Fitting?	☐ Yes ☐ No

I acknowledge receipt of the "Summary of Privacy Practices" (rev. September 23, 2013) and understand that I may request to review the full-length "Notice of Privacy Practices" (rev. September 2013).

Patient Signature:_____ **Date:**_____

I have read and accept the financial and office policy presented to me. I authorize the release of any medical information necessary to process all claims. I also authorize the release of payment of medical benefits to my physician. If my insurance denies the claims, I agree to be financially responsible for my bill.

Patient Signature:_____ **Date:**_____