Patient Demographic Information

Patient Information

Patient Name: ____ Preferred Name: ____________
Last First Middle

Address: ____
Street City State Zip

Home Phone: ________________ Cell Phone: ________________ May we send you text messages? Y N

Email: ____ (To receive appointment reminders, vision and health news and more, please update your email address. Your personal information is kept strictly confidential and never shared.)

Birth Date: _________________________ Social Security Number: ____________________________

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Language: ______________________ Race: __________________ Ethnic Group: __________________

Preferred Pharmacy: ____
City Zip

Patient Employment Information

Occupation: ____________________________ Employer: __________________________________

Address: ____
Street City State Zip

Parent/Guardian/Power of Attorney Information (must be filled out for patients under 18)

Guarantor Name: ___________________________________ Relationship to Patient: ________________
Last First MI

Guarantor DOB: ______________________ Guarantor SSN: _________________________________

Address: ____
Street City State Zip

Guarantor Home Phone: ______________ Work Phone: _______________ Cell Phone: _______________

Patient Insurance Information

Vision Insurance Name: _________________________ ID #: ________________ Group #: ___________

Medical Insurance Name: ________________________ ID #: ________________ Group #: ___________

Insurance policy holder: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Insured SSN: ____________________

Name of Insured: ______________________________________ Insured DOB: ____________________
Last First MI

Insured Address: ____
Street City State Zip

Insured Phone: ___________________________ Insured Employer: _______________________________

Emergency Contact Information

Emergency Contact Name: ____________________________________ Relationship: ________________

Phone Number: ____

Release and Assignment

I authorize the release of any information necessary to process my insurance claims and assign and request payment to my physicians. I understand that eligibility and/or benefits cannot be guaranteed, therefore all outstanding balances left after insurance reimbursement are my responsibility including collection and attorney fees.

Signature: ____ Date: ______________________

All eyeglass and contact lens prescriptions expire one year from exam date unless otherwise specified.