Patient Information

Patient Name _____ Age _____ Date of Birth _____

□ Male □ Female □ Unspecified Marital Status □ S □ M □ W □ D SS# _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Is it ok to text ☐ Yes ☐ No

Email _____ Work Phone _____

If under 18: Parents/Legal Guardian Name(s): _____

Patient Employer/Year in School _____

Guarantor Information ***(Person responsible for payment, if other than above or above is a minor)***

Name _____ DOB _____

SSN _____ Home Phone _____ Cell Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Information

PLEASE SHOW VISION AND MEDICAL INSURANCE CARDS TO THE FRONT DESK

Primary Vision Insurance: _____ **Member Name** _____

Member DOB _____ SSN _____ Phone _____

Member Address _____ City _____ State _____ Zip _____

Supplement Vision Insurance: _____ **Member Name** _____

Member DOB _____ SSN _____ Phone _____

Member Address _____ City _____ State _____ Zip _____

Primary Medical Insurance: _____ **Member Name** _____

Member DOB _____ SSN _____ Phone _____

Member Address _____ City _____ State _____ Zip _____

Supplement Medical Insurance: _____ **Member Name** _____

Member DOB _____ SSN _____ Phone _____

Member Address _____ City _____ State _____ Zip _____

Preferred Method of Contact ***(Select all applicable preferences)*** □ Phone □Mail □ Text □ Email

Race/Ethnicity ***(Select one)*** □ Caucasian □ American Indian or Alaska Native □ Asian □ African American □ Hispanic/Latino □ Native Hawaiian □ Other Pacific Islander □ Not Hispanic/Latino

Preferred Language ***(Select One)*** □English □ Spanish □ Other _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize Blanco Kays Corgiat Eyecare, LLC to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made directly to Blanco Kays Corgiat Eyecare, LLC on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and/or insurance company and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes Blanco Kays Corgiat Eyecare, LLC to act as my agent, as above.

Guarantors are subject to finance fees, collection fees, legal fees, and/or filing charges for delinquent accounts over 120 days.

_____ _____

Lifetime Patient/Guarantor Signature ***Date***