Patient Information Form

Name:_____ Mr.____ Mrs._____ Miss_____ Dr._____ Other:_____

Address:_____ Phone # Home: _____

City:_____ State:_____ Zip:_____ Phone # Work: _____

Date of Birth:_____ Age:_____ Phone # Cell: _____

Occupation:_____ Email: _____

If minor, the name of Father:_____ Mother:_____ Legal Guardian:_____

Do you have Insurance Coverage?	Yes	No

If yes, please list it (them):_____

Name of the Policy Holder:_____

How did you learn of this office?: _____

If you were referred, by whom?: _____

Are there any members in your family that are patients of our office?	Yes	No

If so, please name them: _____

When was your last physical examination? _____

List your Primary Care Physician:

Name: _____

Phone Number: _____

Address: _____

_____

_____

I hereby authorize payment of my medical and surgical insurance benefits to Seesaw Vision EB LLC. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Seesaw Vision EB LLC. I authorize Seesaw Vision EB LLC to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization maybe used in place of the original.

_____ _____

Signature Date