

Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr.						Patient ID:	
Last Name	Middle	First Name	Suffix	Preferred	DOB (mm/dd/yy)	SSN	

Patient's Address		Address Line 2		Primary Phone <input type="checkbox"/> Home <input type="checkbox"/> Mobile	Day/Work Phone
City	State	Zip	Country	Emergency Contact	Emergency Phone
Email			Person responsible for this A/C		

Height	ft	in	cm/m	<input type="checkbox"/> ft in	<input type="checkbox"/> cm	<input type="checkbox"/> m
Weight		<input type="checkbox"/> lbs	<input type="checkbox"/> kg			

Authorized to discuss health info	Name	
	Relationship to patient	

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Employed <input type="checkbox"/>
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Primary Insurance			
Insured's Name (First Name, Middle Initial, Last Name)			
Insured's Address		Address Line 2	
City	State	Zip	Country
Insured's ID No	Group No	Insured's DOB	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F
Pt Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

Secondary Insurance			
Insured's Name (First Name, Middle Initial, Last Name)			
Insured's Address		Address Line 2	
City	State	Zip	Country
Insured's ID No	Group No	Insured's DOB	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F
Pt Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

How did you initially find our office? (Specify one) _____

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____