PATIENT INFORMATION FOR EYE CARE ASSOCIATES

PLEASE PRINT AND FILL IN AS COMPLETELY AS POSSIBLE

PATIENT

First Name _____ MI ___ Last Name _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell Phone _____ Birth Date _____ Sex: M F

Social Security # _____ Email _____

Employer _____ Work Phone _____

Occupation _____

Marital Status (circle) S M Spouse's name _____

Referred by _____

Insurance Vision Insurance (circle) VSP EYEMED SUPERIOR VISION CIGNA NONE

Health Insurance (circle) BCBS UNITED HEALTHCARE AETNA CIGNA MEDICARE OTHER NONE

(please hand insurance card to front desk so we can scan into your record for future use)

RESPONSIBLE PARTY

Name _____ DOB _____ Relationship to Patient _____

Address(if different than above) _____

City _____ State _____ Zip _____ Phone _____

I have received a copy of EYE CARE ASSOCIATES' Notice of Privacy Practices.

Patient/Parent Signature _____ **Date:** _____