WELCOME TO OUR OFFICE

Patient Information

Today's Date ______________________

Last Name ______________________

First Name ______________________ **MI** ______

Street ______________________

City ______________ **State** _____ **Zip Code** _______

SSN ______________ **DOB** ______________

Age __________ **Sex** ☐ **M** ☐ **F**

Language ☐ *English* ☐ *Spanish* ☐ *French*
☐ *Japanese* ☐ *Decline to specify*

Race ☐ *American Indian, Alaska Native* ☐ *Asian*
☐ *Black or African American* ☐ *Hispanic*
☐ *Native Hawaiian/ Other Pacific Islander*
☐ *White* ☐ *Decline to specify*

Ethnicity ☐ *African American* ☐ *Asian*
☐ *Euro American* ☐ *Hispanic or Latino*
☐ *Native Hawaiian/Other Pacific Islander*
☐ *Not Hispanic or Latino* ☐ *Decline to specify*

Home Phone ______________ **Cell** ______________

Email Address ______________________

Preferred Contact Method:

☐ *Home phone* ☐ *Cell phone* ☐ *Email* ☐ *Text*

☐ *Other* ______________________

Employer (or School) ______________________

Occupation (or Grade) ______________________

Work Phone ______________________

☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Separated* ☐ *Widowed*

Emergency Contact Name ______________________

Emergency Contact Phone ______________________

Medical Doctor ______________________

City ______________ **Phone Number** ______________

Consent for use and disclosure of health information. Purpose of consent: By signing this form, you will consent to our office use and disclosure of your protected health information to carry out treatment, payment and healthcare operations.

Signature: ______________________

Insurance Information

Vision Insurance ______________________

Subscriber Name ______________________

Subscriber SSN ______________ DOB ______________

ID# ______________ Grp# ______________

Primary Medical Insurance ______________________

Subscriber Name ______________________

Subscriber SSN ______________ DOB ______________

ID# ______________ Grp# ______________

Secondary Medical Insurance ______________________

Subscriber Name ______________________

Subscriber SSN ______________ DOB ______________

ID# ______________ Grp# ______________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to InSight Eyecare Associates. All insurance benefits, if any, otherwise payable to me, for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

______________________ ______________
Relationship Date

New Patients ONLY

Who may we thank for referring you to our office?

Name of friend or relative:

____

If not referred, how did you choose our office?

☐ *Another Doctor* ☐ *Insurance List*

☐ *Saw Sign/Building* ☐ *Yellow Pages*

☐ *Web Page:* ______________________

☐ *Other* ______________________

Our Mission is to provide a lifetime of healthy vision for all our patients by providing professional and compassionate care with the latest technology.

SEE NEXT PAGE