

Welcome to Family Eye Care Center

Please take a moment to complete the following information.
If you have any questions, please do not hesitate to ask.

Mr. Miss Mrs. Ms.

Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Work Phone

Email Address Guardian Person Responsible for Account

Emergency Contact Emergency Phone

Whom may we thank for referring you?

Primary Insurance Information

Name and Address of Primary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Self Spouse Child Other

Patient Status

Single Married Other
 Full Time Student Part Time Student Employed

Secondary Insurance Information

Name and Address of Secondary Insurance Company City State Zip

M F

Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured

Self Spouse Child Other

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 the Family Eye Care Center.

Signature

Date

Please turn over and fill out the back page