WELCOME TO FAMILY EYECARE CENTER

Please take a moment to complete the following information.
If you have any questions, please ask us.

Patient Information

□ Mr. □ Mrs. □ Ms. □ Child □ Male □ Female

First Middle Last Preferred Name

Address:_____ City:_____State_____ Zip:_____

Social Security#_____/_____/_____ Date of Birth:___/_____/_____

Email Address _____(only for office communication, we respect your privacy)

Phone: Cell:(____)_____ Home:_(____)_____

May we contact you via Text for appointment confirmation? Y___ N___ (Standard text message charges may apply)

Whom may we thank for referring you? _____

Primary Insurance Information: Vision Insurance: □ VSP □ EYEMED □ Medical Eye Service □ Other _____

Who is Policy Holder (Insured)?: □ Self □ Spouse □ Child □ Domestic Partner □ Other

Patient's Status: □ Single □ Married □ Child □ Employed □ Full Time Student □ Other

Insured's Name:_____
First Middle Last

Insured's Employer_____ Primary Medical Insurance_____

Insured's Medical ID No.:_____ Group No.:_____ Date of Birth:_____/_____/_____

Insurance Company Phone No.:_(____)_____

Insured's Phone No.:(____)_____□ Home □ Cell

Secondary Insurance Information: Vision Insurance: □ VSP □ EYEMED □ Medical Eye Service □ Other _____

Who is Policy Holder (Insured)?: □ Self □ Spouse □ Child □ Domestic Partner □ Other

Secondary Insured's Name:_____
First Middle Last

Secondary Insured's Employer_____ Secondary Medical Insurance_____

Secondary Insured's Medical ID No.:_____ Group No.:_____

Secondary Insured's Date of Birth:_____/_____/_____

Secondary Insurance Company Phone No.:_(____)_____

Secondary Insured's Phone No.:(____)_____□ Home □ Cell

PAYMENT TERMS: See attached form.

I have read and agree to the attached provisions of the office financial policy.

Dated:_____ x_____
Patient's Signature