Patient Data

Today's Date:________________

PATIENT INFORMATION

Patient's Last Name:	Patient's First Name:	Patient's Middle Name:
Race / Ethnicity: ☐ American Indian ☐ Asian ☐ African American ◻ Hispanic ☐ Native Hawaiian ☐ White ☐ Other		**Preferred Language:** ☐English ☐Spanish ☐Other

Date of Birth:	Sex: ☐Male ☐Female	SSN:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widow
Street Address:		**Mailing Address (if different):**	

City:	State:	Zip Code:	Home Phone:	Work Phone:

Employer:	Cell Phone:	Text OK? ◻ Yes ◻ No	Email:

FOR MINOR PATIENTS ONLY

Father's Name:	Cell Phone:	Alternate Phone:
Father's Employer:	**Street, City, State, Zip:**	
Mother's Name:	**Cell Phone:**	**Alternate Phone:**
Mother's Employer:	**Street, City, State, Zip:**	

CONTACT INFORMATION

Emergency Contact:	Phone Number:	Relationship:
Address (If Different):	**City** (If Different):	**State** (If Different):

INSURANCE INFORMATION

Vision Insurance:

Insurance Company:		Relationship to Insured ☐Self ☐ Spouse ☐Child ☐Other
Policy Holder:	**Policy Identification Number:**	**SSN:**
Group Number:	**Holder Date of Birth:**	**Gender:** ☐Male ☐Female

Primary Medical Insurance:

Insurance Company:		Relationship to Insured ☐Self ☐ Spouse ☐Child ☐Other
Policy Holder:	**Policy Identification Number:**	**SSN:**
Group Number:	**Holder Date of Birth:**	**Gender:** ☐Male ☐Female

Other Insurance:

Insurance Company:		Relationship to Insured ☐Self ☐ Spouse ☐Child ☐Other
Policy Holder:	**Policy Identification Number:**	**SSN:**
Group Number:	**Holder Date of Birth:**	**Gender:** ☐Male ☐Female

I hereby authorize assignment of benefits to be paid directly to the doctor. This will remain in effect until revoked by me in writing. The Patient/guardian is responsible for all fees regardless of insurance coverage. Payment for services is expected at time of appointment, unless other arrangements have been made. I understand that I am responsible for payment in full for all coinsurance, deductibles, as well as any doctor's services which are determined to be non-covered. I authorize my physician to release any medical information necessary to process my bill. Further, I have read the HIPPA privacy notice given to me at the time of my appointment. I hereby authorize that all insurances provided above are complete and accurate and I understand that any insurance provided after the date of service cannot be filed.

Signature:	**Date:**