WELCOME to EYE CONCEPTS!

To help us better serve you, please take time to fill out information below. Thank you. ☺

Patient Profile

Title:____ First: _____ MI:___ Last:_____

Address:_____

City:_____ State:_____ Zip:_____

Home phone:_____ Work:_____

Cell Ph: _____ Email Add: _____

Birth date:_____ Sex:_____ SSN:_____

Guardian (if a minor)_____ Relationship_____

Emergency contact_____

Relationship _____ Phone _____

Lifestyle

Marital Status:_____ Occupation:_____

Hobbies:_____

Sports: _____

Referral

Source: o Family o Friend o Patient o Physician o Other

Referral Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Demographics

Employer

Employer Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Guarantor (Primary Insured)

Patient's Relationship:_____ Phone:_____

Title:____ First: _____ MI:___ Last:_____

Address:_____

City:_____ State:_____ Zip:_____

Home phone_____ Mobile_____ Work_____

Birth date:_____ Sex:_____ SSN:_____

Financial

Preferred Payment Method: Visa / MC /Amex / Disc /Check /Cash

Vision Insurance _____ID number_____

Medical Insurance _____ ID number_____

Policy Group _____

Insured Party: o Self o Patient o Other

Relationship to Insured:_____

INSURANCE ASSIGNMENT & RELEASE:

I, the undersigned, certify that I, or my dependent, have read and understood the HIPAA notice and have insurance coverage with the company named by me above and assigned directly to Eye Concepts, LLC all insurance and/or other company 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 any third party. I hereby authorize Eye Concepts, LLC to release all information necessary or appropriate (including protected health information) to my employer or any other third party to collect such benefits or unpaid amounts. I authorize the use of this signature on all insurance or other submissions.

Responsible Party Signature_____Relationship_____