

Adult

PATIENT INFORMATION				Today's Date:		
Last Name:	First Name:	M.I.	Nickname:	Gender:	Age:	Birthdate:
Telephone: (Home)	(Work)	(Cell)		Social Security Number:		
Address:		City:		State:	Zip Code:	
Employer:		Marital Status:		E-Mail Address:		
Employment Status:		Occupation:		Referred to this office by:		
Communication Preference Circle all that Apply: E-Mail Postal Telephone Cell						
May we send text messages to your cellular phone? Yes No (appointment reminders, etc)						
Preferred Language:	Race: American Indian/Alaska Native Asian					
African American		Hispanic		Native Hawaiian/Other Pacific Islands		White

SPOUSE'S INFORMATION					
Name:			Date of Birth:		
Address:		City:		State:	Zip Code:
Telephone: (Home)		(Cell)		Social Security Number:	
Employer:			Occupation:		
Employer's Address & Phone:					

LEGAL GUARDIAN'S BILLING INFORMATION (if appropriate)					
Name:					
Address:		City:		State:	Zip Code:
Telephone: (Home)		(Cell)		Social Security Number:	

NEAREST RELATIVE NOT LIVING WITH YOU					
Name:			Relationship:		
Address:		City:		State:	Zip Code:
Telephone: (Home)		(Cell)		Social Security Number:	

INSURANCE INFORMATION	Primary Vision or Medical Ins	Secondary Vision or Medical Ins
Name of Insurance Company:		
Name of Employee:		
Employee's SSN:		
Employee's Birth Date:		
Employee's ID Number:		
Employee's Group Number:		

While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

I certify that the above is correct and I realize that if the account is not paid all collection fees, attorney fees, and court costs incurred to collect the balance of the account also becomes my responsibility.

Signature