Welcome

We are pleased to welcome you to our practice. Please fill out this form as completely as possible. In compliance with HIPAA and insurance requirements, yearly updates are required. If you have questions we are glad to help…

Patient Name: _____
Last First Middle Nickname or Preferred

Address _____
Street or P.O. Box City State Zip

Your Date of Birth_____/_____/_____ SS# _____-_____-_____ e-mail _____

Phone numbers cell (_____) _____-_____home (____) _____-_____work (____) _____-_____

Preferred Communication: ☐Telephone ☐Email ☐Postal ☐Text Preferred language: ☐English ☐Spanish

Race: ☐White ☐African Am ☐Hispanic ☐Asian ☐Other

Ethnic group: ☐White ☐Hisp/lantino ☐Non Hisp ☐Other Gender: ☐male ☐female

Employer _____ Family Doctor _____

Your Preferred Pharmacy _____

If married, name of spouse _____ Spouse employed by _____

If under 18, parent or guardian's name _____

Relation _____ Phone _____-_____ Employer _____

Emergency Contact Name:_____Relationship:_____ Phone(____)_____-_____

Who may we thank for referring you? _____

Insurance Information

How will you be paying today? ☐ Full payment by cash, check, or credit card ☐ Vision Care insurance

Insurance information must be presented at the time of visit, and cannot be changed after date of service.

Policy Holder Name:_____SS#_____Date of Birth____/____/____

Primary Ins.
Company_____ID#_____Group#_____

Secondary Ins
Company_____ID#_____Group#_____

Relationship to the Patient:_____

"I, the undersigned , certify and assign to the doctor all insurance benefits. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any and all collection methods. This authorization can only be rescinded by written notice.

"I also acknowledge that I have had an opportunity to receive a copy of the Privacy Practices and Policies of this practice."

_____
signature date