PATIENT INFORMATION

Please check the information on this report for accuracy. Please make corrections and fill in any missing information. Thank you for your cooperation.

NAME:					
ADDRESS:					
CITY:		**STATE:**		**ZIP:**	
HOME PHONE:				**CELL:**	
WORK PHONE:					
BIRTHDATE:				**MARITAL STATUS:**	
SOCIAL SECURITY NUMBER:					
OCCUPATION / GRADE:					
EMPLOYER / SCHOOL:					
EMAIL ADDRESS:					

INSURANCE INFORMATION

INS. CO.	ID NUMBER	SUBSCRIBER	SUBSCRIBER ID	SUBSCRIBER BIRTHDATE
VISION				
MEDICAL				

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

☐ Guardian

X_____ _____

DATE

INSURANCE AUTHORIZATION

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to:

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X_____ _____

DATE