Eye Solutions, Inc.

Thank you for choosing our office for your eyecare needs.
If you have any questions or concerns please ask our staff. We would be happy to help you.

Patient Information:

Name:_____ Preferred name:_____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work:_____ Mobile:_____
Birthday:_____ SSN:_____ Sex: □Male □Female
Email:_____ Employer:_____ Occupation:_____
Race: □White □Asian □American Indian □Black/African American □Hispanic □Other
Preferred language:_____
Please check which applies to you: □ Minor □Married □Divorced □Single □ Widow
Spouse or Guardian name:_____ Phone:_____
Person Responsible for this Account:_____ Phone:_____
Address (if different):_____
Whom may we thank for referring you? _____

Insurance Information:

We do ask for copies of both your medical and vision insurance cards. Please take all insurance cards to the front desk.

Vision Insurance:_____
Name of policy holder:_____
Social Security Number:_____ Date of Birth:_____
Address (if different):_____
Telephone number (if different):_____

Primary Medical Insurance:_____
Name of policy holder:_____
Social Security Number:_____ Date of Birth:_____
Address (if different):_____
Telephone number (if different):_____

Notice of Privacy, Patient Consent and Payment information:

I further request that necessary testing be preformed for diagnostic, treatment and education purposes. Even if I have vision insurance coverage, I am responsible for all charges incurred for optometric services and products at this clinic. I authorize the release of any information including examination findings and diagnosis rendered to me or to my child to third party payers and/or health care providers. I authorize the doctor to act as my agent in helping me obtain payment of my insurance.

Signature:_____ Date:_____

Please list all other people allowed to access this patient's medical information:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____