

# 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 performed 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: \_\_\_\_\_