

ADVANCED VISION CARE "WELCOME TO OUR OFFICE"

PATIENT INFORMATION, PLEASE FILL OUT COMPLETELY

DATE _____

NAME _____ NAME YOU LIKE TO BE CALLED _____

BIRTH DATE _____ AGE _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

EMAIL _____ CELL PHONE _____

EMPLOYER/SCHOOL _____ GR. _____ OCCUPATION _____

REFERRED TO OFFICE BY _____ OR THROUGH:

SIGN/LOCATION YELLOW PAGES ADVERTISING INSURANCE PLAN

OTHER FAMILY MEMBERS LIVING AT HOME:

IF CHILD, NAME OF FATHER _____ MOTHER _____

SPOUSE _____

CHILDREN _____

IF NOT COVERED BY INSURANCE, NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

MEDICAL INSURANCE INFORMATION

NAME OF MEDICAL INSURANCE _____

INSURED'S NAME _____ INSURED'S BIRTHDATE _____

ADDRESS SAME AS ABOVE _____ CITY _____ ZIP _____

PHONE: HOME _____ WORK _____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER, EXPLAIN _____

VISION INSURANCE INFORMATION

NAME OF VISION INSURANCE _____

INSURED'S NAME _____ LAST 4 DIGITS OF SOCIAL SECURITY # _____

ADDRESS SAME AS ABOVE _____ CITY _____ ZIP _____

PHONE: HOME _____ WORK _____

RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER, EXPLAIN _____

PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST SO THAT WE MAY MAKE COPIES

NAME OF YOUR PRIMARY CARE PHYSICIAN _____

OFFICE LOCATION _____ PHONE _____

DATE _____

Signature of Patient (or parent if minor)

THANK YOU FOR GIVING US THIS INFORMATION.

PROTECTED HEALTH INFORMATION

I authorize Advanced Vision Care to share my medical information with _____

(relationship) _____

Signature _____

MEDICARE PATIENTS ONLY: Please Read and Sign

I Request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Vision Care for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signature of Patient or Authorized Person

DATE _____

DO YOU HAVE SUPPLEMENT INSURANCE? YES NO

SUPPLEMENTAL INSURANCE NAME _____