Thank you for choosing the Eye Care Center

Please fill in the form below fully and completely. Questions about Race, Ethnicity and Language are required to be asked under the new Health Care Reform guidelines as is email address to comply with electronic requirements. If you have questions please feel free to ask!

Section 1: Patient Information

Name:	**Preferred Name (nickname):**
Sex:	**Date of Birth:**
Street Address (include apt # or Unit): **City:** **State:** **Zip:**	**Home Phone:** **Work Phone:** **Cell Phone:** (_____)_____ **Text Carrier:** _____ (ie: Verizon, T-Mobile etc) **Email: (*please enter*):** **My preferred method of contact is (circle one):** Phone Email Text Msg
Social Security Number:	**Marital Status (circle one):** Single Married Divorced Widowed Other
Preferred Language (please write in if other than English):	**How were you referred to us?** ☐ Yellow Pages ☐ Insurance ☐ Website ☐ DexOnline ☐ Community Event ☐ Saw signage/drive-by ☐ Friend or Family (can we have their name?)_____ ☐ Other (please specify) _____
Race (check one) ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ White/Caucasian ☐ Other Race ☐ Decline to answer	**Ethnicity: (check one)** ☐ Not Hispanic/Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer
Employer: (*please enter*)	**Position:**

Section 2: Person Financially Responsible For This Account

Name:	**Date of Birth:**
Relationship to Patient (circle one): Self Spouse Parent Other: _____	**Social Security Number:**
Street Address:	**Home Phone:** **Work Phone:** **Cell Phone:** (_____)_____
City/State/Zip:	
Employer: (*please enter*)	

Section 3: Insurance Information

Initial here if there are no changes to the information below _____

Primary Insurance	**Secondary Insurance**
Name of Insurance:	**Name of Insurance:**
Name of Policy Holder:	**Name of Policy Holder:**
Policy Holder's Date of Birth:	**Policy Holder's Date of Birth:**
Relationship to Patient (circle one): Self Spouse Parent Other: _____	**Relationship to Patient (circle one): Self Spouse Parent Other: _____**
Employer: (*please enter*)	**Employer: (*please enter*)**

Section 4: Authorization and Acceptance

I authorize the release of any information, including records of any treatment or examination rendered to me or my child during the period of care, to third party payers and/or clinic insurance benefits otherwise payable to me. I understand my insurance may pay less than the total amount due. I understand that I am responsible for any portion of my account not paid by insurance within 60 days. I have no insurance or if my insurance plan has no formal agreement with the clinic, I understand I am responsible for my entire account balance when services and/or materials are delivered to me. I understand and agree that there will be a Late Charge of $5 per month of any past due acct over 60 days. I also agree that if I am in default of this agreement, I will pay all reasonable & legal fees, court costs, & other costs necessary to collect the debt, including fees charged by a collection agency.

Signature: _____ **Date:** _____