DATA / INSURANCE QUESTIONAIRE

Patient Information	Insurance Information
Last _____ First _____MI _____ Date of Birth _____ Age _____ Sex M or F Race ○ Asian ○ Black ○ White ○ Native Indian Ethnicity ○ Hispanic/Latino ○ Non-Hispanic/Latino Preferred Language _____ Street _____ City _____ State _____ Zip Code _____ Home Phone _____ Cell Phone _____ Work Phone _____ Email _____ Spouse/Parent's Name _____ Employer/School _____ Occupation/Grade _____	**Please be advised if you are using insurance benefits - the contract is between you and your insurance company - NOT the Eye Site Center.** ***Also note <u>most</u> insurance plans do NOT cover the Contact Lens Evaluation or Follow-Ups.*** ***Vision:*** _____ Primary's Name_____ Primary's ID_____ Primary's Birth Date_____ ***Major Medical:***_____ Primary's Name_____ Primary's ID_____ Primary's Birth Date_____ ***Supplemental:*** _____ Primary's Name_____ Primary's ID_____ Primary's Birth Date_____ **If your insurance company has not reimbursed our office within 60 days, <u>you may be billed</u> for any services or products that you have received.**
NEW PATIENTS ONLY: Who may we thank for referring you to our office? ❑ Another Dr. ❑ Insurance List ❑ Saw Sign/Building ❑ Printed Directory? ___ ❑ Web Page _____ ❑ Other _____	**OFFICE USE ONLY** ____ HIPPA ____ SOF ____ Relationship ____ Insurance ____ Recall ____ Exam Invoice ____ Mats Invoice **Co-Pay** _____ **CL Eval** _____ **Other** _____