PATIENT FINANCIAL AND INSURANCE INFORMATION

PATIENT NAME: _____ **GENDER: MALE / FEMALE**
(Please Print) Last Name, First Name, Middle Initial (Please circle)

DATE OF BIRTH(MM/DD/YYYY):_____/_____/_____**SOCIAL SECURITY NUMBER** (last four): _____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
HOME PHONE:(_____)_____ WORK PHONE:(_____)_____CELL PHONE:(_____)_____
EMAIL ADDRESS: _____

EMERGENCY CONTACT AND NUMBER: _____
Person(s) we can discuss and or release your health information to:
Self only___Name(s)_____
May we leave a voicemail/email about your health information: Yes_____ No_____

RACE (Choose one): _____Asian _____Black _____White _____Native American _____Pacific Islander
Other _____ **ETHNICITY** (Choose one): ___ Hispanic ___ Not Hispanic

Employer: _____ Occupation: _____

NAME OF VISION INSURANCE: _____**ID#**: _____
SUBSCRIBER INFORMATION
NAME: _____DATE OF BIRTH: _____SS# (last four): _____
RELATIONSHIP TO PATIENT:_____ WORK PHONE:(____)_____

PRIMARY MEDICAL INSURANCE: _____**ID#**: _____
SUBSCRIBER INFORMATION
NAME: _____DATE OF BIRTH:_____SS# (last four):_____
RELATIONSHIP TO PATIENT:_____ WORK PHONE:(____)_____

SECONDARY MEDICAL INSURANCE: _____ ID#: _____
NAME: _____DATE OF BIRTH: _____SS# (last four):_____
RELATIONSHIP TO PATIENT:_____ WORK PHONE:(____)_____

Medical Release Authorization and Insurance Assignment:
I, the undersigned authorize payment from my insurance company to be made to Crystal Clear Eye Care (CCEC) for covered services. I understand that I am responsible for obtaining any referrals needed before my appointment or I must pay for that visit. Regardless of my insurance's status, I am ultimately responsible for the balance on my account. Should timely payments of this account not be made, I authorize CCEC to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance. Any expenses incurred by such an action shall become an additional liability for which I am responsible. I certify that the information I have recorded about my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company to determine insurance benefits to which I may be entitled, this authorization may be revoked by myself at any time in writing.

_____ _____ _____
PRINT NAME SIGNATURE DATE

I have reviewed a copy of the Privacy Policy for Crystal Clear Eye Care.

_____ _____ _____
PRINT NAME SIGNATURE DATE