PATIENT INFORMATION FORM

PLEASE UPDATE THE FOLLOWING INFORMATION

NAME ______________________________

Marital Status: Single/Divorced, Married, Other
(Please Circle One) Mr., Mrs., Ms., Dr., Sr., Miss

ADDRESS ______________________________
STREET CITY STATE ZIP

HOME TELEPHONE __________ CELL __________ E-MAIL ADDRESS __________

DATE OF BIRTH ____/____/____ SOCIAL SECURITY # __________

SPOUSE OR PARENT'S NAME __________ SOCIAL SECURITY # __________

PHARMACY/LOCATION ______________________________

FAMILY DR. __________ PHONE # __________

❑ Please check box if you wish to be contacted via e-mail or text for appointment reminders.

REASON FOR TODAY'S VISIT ______________________________

____

REFERRING DR./SOURCE ______________________________

EMPLOYMENT INFORMATION

PATIENT'S OR RESPONSIBLE PARTY'S EMPLOYER __________ TELEPHONE __________

OCCUPATION: ______________________________

INSURANCE INFORMATION

MEDICARE # __________

INSURANCE CO. __________ INSURED'S DATE OF BIRTH ____/____/____

ID/POLICY # __________ INSURED'S SSN __________

GROUP # __________ INSURED NAME & RELATIONSHIP __________

VISION INS.: ❑ VSP ❑ EYEMED ❑ SUPERIOR VISION ❑ AMBETTER

INSURANCE AUTHORIZATION AND CONSENT FOR EXAMINATION (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE THE LASTER EYE CENTER TO GIVE MY INSURANCE COMPANY OR COMPANIES, MY ATTORNEY, OR MY PHYSICIAN, ANY AND ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE. I HEREBY ASSIGN TO THE CLINIC ALL PAYMENTS FOR MEDICAL SERVICES, SHOULD IT DESIRE TO TAKE SUCH ASSIGNMENT. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. I FURTHER AUTHORIZE THE DOCTORS AND STAFF OF THE LASTER EYE CENTER TO EXAMINE MY EYES AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH AN EYE EXAMINATION.

____
(SIGNED) DATE

____
(RESPONSIBLE PARTY OR PARENT IF PATIENT IS MINOR)

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