PATIENT INFORMATION FORM

PLEASE UPDATE THE FOLLOWING INFORMATION

NAME ______________________________

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 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 UNDERSTAND AND AGREE I AM RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COLLECTIONS AND/OR ATTORNEY FEES NECESSARY TO COLLECT THIS DEBIT. ONCE THE ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, A FEE OF 30% OF THE BALANCE DUE WILL BE ADDED TO THE TOTAL. I AUTHORIZE THE DOCTORS AND STAFF OF LASTER EYE CENTER TO EXAMINE MY EYES AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH AN EYE EXAMINATION.

____
(SIGNED) DATE

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(RESPONSIBLE PARTY OR PARENT IF PATIENT IS MINOR)

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