PATIENT INFORMATION FORM

Patient's Full Name: Address: Social Security # Social Security #	Today's Date:	
Address: Street Cell Phone: Cell Phone: Do you accept text messages: Y / N		Date of Birth:
Home Phone: Cell Phone: Do you accept text messages: Y / N Email: How do you prefer to be contacted: Cell Phone / E-mail / Text Employer: Work Phone: Work Phone: Spouse's Name: Work Phone: Phone: To notify In Case of Emergency? Phone: Race: white black hispanic asian indian other MALE FEMALE For Children, Please Fill out This Section: Name: Maders: Father guarantor? Mother guarantor? Name: Address: City/SuZip DOB Social Security # DOB Employer: Employer: Employer: Phone: Phone: ID # Mother Self Spouse Vision Insurance: ID # Medical Insurance: ID # Medical Insurance: ID # Medical Insurance: Address of Member We will need to make copies of your cards) **Assignment of Benefits** I hereby assign all medical and/or vision benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Advance Family EyeCare. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patier record. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as a original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize assorting and to recease of the patier record. Signature of Signature of Date Date Date Date Date		Social Security #
Employer:		State Zip
Employer:		
Spouse's Name:		
To notify In Case of Emergency? Race: white black hispanic asian indian other MALE FEMALE For Children, Please Fill out This Section: Father guarantor? Mother guarantor? Name: Name: Address: City/St/Zip DOB Social Security # DOB DOB Employer: Phone: Phone: Phone: DOB DOB		
Race: white black hispanic asian indian other		
For Children, Please Fill out This Section: Father		
Name:	Race: white black hispanic asian indian	other MALE FEMALE
Name:	For Children, Please Fill out This Section:	
Address:	Father ☐ guarantor?	Mother ☐ guarantor?
Address:	Name:	Name:
City/St/Zip Social Security # DOB Social Security # DOB Employer:		
Social Security #	City/St/Zip	
Employer: Phone: Phone: Phone: Phone: ID #		
Who is PRIMARY INSURANCE under? Father Mother Self Spouse Vision Insurance: ID #	Employer:	
Who is PRIMARY INSURANCE under? Father Mother Self Spouse Vision Insurance:		
Vision Insurance:	Will be better the second of t	
Medical Insurance: SS# of Primary Member SS# of Primary Member Address of Member Address of Member Address of Member (We will need to make copies of your cards) ### Address of Member Address of Member		Spould:
Phone# of Primary Member Address of Member (We will need to make copies of your cards) Assignment of Benefits I hereby assign all medical and/or vision benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Advance Family EyeCare. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patier record. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as a original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment. Patient Signature Date		
Phone# of Primary Member Address of Member (We will need to make copies of your cards) **Assignment of Benefits** I hereby assign all medical and/or vision benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to Advance Family EyeCare. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patier record. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as a original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment. Patient Signature	Medical Insurance:	ID#
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Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. The ultimate responsibility for payment to the optometrist lies with you.

Privacy and Health information will be given on iPad