PATIENT INFORMATION FORM

Date_____/_____/_____

Patient legal name:_____ Preferred Name:_____
Date of Birth_____/_____/_____ Gender:_____ Social Security #_____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Address:_____City_____State_____Zip_____
Home Phone #:_____Cell Phone #:_____
Email Address:_____
Methods that we may use to contact/text/leave messages for you: ☐ Home # ☐ Cell # ☐ Email
Who may we thank for referring you to our office?_____

RESPONSIBLE PARTY

Name of responsible party:_____Relationship to patient_____
Address (if different from above)_____City_____State___Zip_____
Email:_____Cell Phone #:_____Driver's license #:_____
Occupation:_____Is this person a patient in our office ☐ Yes ☐ No

EYE CARE INSURANCE INFORMATION

PRIMARY EYE CARE INSURANCE
Name of insured:_____Social Security#_____
Relationship: _____ Employer_____Work #_____
Business Address:_____City_____State_____Zip_____
Eye insurance company_____
Member ID #_____Group ID #_____

SECONDARY EYE CARE INSURANCE (If applicable)
Name of insured:_____Social Security#_____
Relationship: _____ Employer_____Work #_____
Business Address:_____City_____State_____Zip_____
Eye insurance company_____
Member ID #_____Group ID #_____

IN CASE OF EMERGENCY

Name:_____Relationship_____
Home #_____Cell #_____Work #_____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any remaining balance. I also authorize Premier Eyecare of Roswell or the insurance company to release any information required to process my claims. Furthermore, I hereby authorize Premier Eyecare of Roswell to disclose any necessary information to affiliated third party vendors as required to complete orders on my behalf; including but not limited to prescriptions, emails, and other contact information.

I hereby authorize Premier Eyecare of Roswell to contact me via unsecure electronic communication (this includes but is not limited to email messages and email reminders). ☐ Yes ☐ No

_____ _____
Patient/Guardian signature Date