WELCOME TO EYEDENTITY EYECARE

Patient Name: Last: ______________________________ First: ______________________ MI: ___________

Date of Birth: _______/_______/_________ Last 4 of SSN: ____________ Sex: □ Male □ Female

Address: ________________________________ City:____________________ State: ______________ Zip __________

Home Ph #_______________________ Work Ph # _______________________ Cell Ph # _________________________

Can we notify you by email for appointments? □ Yes □No Email Address ____________________________________

Employer: ____________________________________ Occupation: ____

Marital Status: □ Single □ Married □Divorced □ Widow

INSURANCE INFORMATION

Primary Carrier

Policy Holder Name: ____ Date of Birth: _______/_______/_________

Relationship to Patient: ____ Last 4 of SSN: ____________

Name of Vision Insurance: ____ ID# ________________________________

Name of Health Insurance: ____ ID# ________________________________

Secondary Carrier

Policy Holder Name: ____ Date of Birth: _______/_______/_________

Relationship to Patient: ____ Last 4 of SSN: ____________

Name of Vision Insurance: ____ ID# ________________________________

Name of Health Insurance: ____ ID# ________________________________

Check any of the following that you have or have had:

Do you wear glasses □ Yes □ No If Yes, how old is your present pair of glasses? _________ Do you wear sunglasses? □ Yes □ No

Do you wear contact lenses? □ Yes □ No Type of contact lenses? □ Rigid □ Soft □ Extended Wear □ Other _______________

Have you had refractive surgery? □ Yes □ No If Yes, when? ____

How many hours a day do you use a desktop/laptop? ____

Payment for services is due on the day of your visit. We file insurance for all plans for which we are a provider. If we are not a provider, in some cases we can file your claim so that you may be reimbursed. You are liable for any co-payments, deductibles and any charges which may not be covered under your plan. A deposit is required for processing any material orders with the balance due on delivery.

Patient or Responsible Party Signature: ____ Date: _____/_______/______