

Welcome to Associated Eye Care Services, L.L.C.

Appointment Date: _____, 200__ __:__ m

<u>title</u> <u>first name</u> <u>middle name or initial</u> <u>last name</u>		<u>preferred name</u>	<u>if patient is a child, parent's name</u>
<u>mailing address</u> (street, city, state, zip code)		<input type="checkbox"/> male <input type="checkbox"/> female	<u>parent's address, if different from at left</u>
		<u>date of birth</u> (mm/dd/yy) / /	
I prefer you contact me <input type="checkbox"/> by postal mail at the address shown above		<u>if patient is a student, circle which grade</u>	
<input type="checkbox"/> by day phone: () -		Preschool K 1 2 3 4	
<input type="checkbox"/> by home phone: () -		5 6 7 8 9 10 11 12	
<input type="checkbox"/> by my email: @		school:	
<input type="checkbox"/> by other means:		teacher:	
<u>social security #</u>	<u>significant other</u>		How Did You Choose Us? <input type="checkbox"/> Our Web Site <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Booklet <input type="checkbox"/> Family Has Been In <input type="checkbox"/> Primary Care Doctor <input type="checkbox"/> Eye Specialist Doctor <input type="checkbox"/> In Building, Stopped By <input type="checkbox"/> Lecture/Health Fair <input type="checkbox"/> Referred by Patient <input type="checkbox"/> Other _____
<u>employer & work address</u>	<u>emergency contact name, phone, email</u>		
<u>vision insurance name & address</u>	<u>insured name</u>		
	<u>group #</u>	<u>ID #</u>	
<u>medical insurance name & address</u>	<u>insured name</u>		
	<u>group #</u>	<u>ID #</u>	
<u>financially responsible party</u>	I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to myself or the party who accepts assignment above. signed: _____ print name: _____		I authorize payment of medical benefits to the above listed physician or supplier for services rendered. signed: _____ print name: _____
<u>payment preference</u> <input type="checkbox"/> Insurance <input type="checkbox"/> Check <input type="checkbox"/> Charge Card <input type="checkbox"/> Cash Payment is expected at the time services are rendered, including non-covered portions of insurance.			
<u>family physician name & address</u>	Internal Use Only Acct. #: _____ FD Initials: _____ Waivers Signed (ABN, Finance, HIPPA)? Y N Time: _____ Photograph Taken? Y N Copies of Insurance? Y N Address/Phone Number/email Verified? Y N		