EMINENCE
FAMILY EYECARE

Date:_____

New Patient information

Last Name: _____

First Name: _____ MI _____

Date of Birth: _____ Age_____

Social Security #: _____

Street address: _____

City/Zip: _____

Occupation: _____

Employer: _____

Marital Status: Single Married Other _____

Gender: Male Female

Preferred Phone (Circle one): Home Cell Work

Home:_____

Cell: _____

Work: _____

Email: _____

Emergency Contact: _____

Emergency Phone: _____

Referred By: _____

If not referred, how did you hear about us?
[ ] Website
[ ] Insurance List
[ ] Saw sign/Building
[ ] Another Doctor
[ ] News Paper/Radio/TV
[ ] Online Search
[ ] Friend or Relative Name:_____

Insurance Information

Vision Insurance: _____

Policy Holder Name: _____

Policy Holder SSN / ID#: _____

Policy Holder Birth Date:_____

Primary Medical Insurance: _____

Policy Holder Name:_____

Policy Holder SSN / ID#: _____

Policy Holder Birth Date: _____

Secondary Medical Insurance: _____

Policy Holder Name: _____

Policy Holder SSN / ID#: _____

Policy Holder Birth Date:_____

ASSIGNMENT OF BENEIFTS/ FINANCIAL RESPONSIBILITY
I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Eminence Family Eyecare unless payment is made in full at time of service. I agree to bear full responsibility for co-pays, deductibles, non-covered or denied services by my insurance.

Signature: _____

Date: _____

Relationship to Patient (If minor): _____