Patient Information

Name: (Last) ______________________ (First) ____________________ (M) _________ Nickname: _____________

Gender: Male Female Birth Date: ____/____/______ Social Security #: ____________________________

Address: ____________________________________ Home Phone: ______________________________

____________________________________ Work Phone: ______________________________

Email Address: __________________________________ Occupation: ________________________________

Cell Phone:________________________________ Employer: ________________________________

Do not send: ☐emails ☐text messages Marital Status: ______________________________

Responsible Party Information

Person responsible for patient account: ______________________________Relation to patient: _______________

Social Security #: ____________________ Date of Birth: ___/___/_____ Occupation: _________________________

Address: ____ Employer: ___________________________

Health/Medical Insurance Information

Primary Insurance: _________________________________ Policyholder Name: ____________________________

Policyholder Social Security#:____________________ Date of Birth:___/___/___ Relation to patient: __________

Policyholder Address (if different): ____

Secondary Insurance: _________________________________Policyholder Name: ____________________________

Policyholder Social Security#:__________________ Date of Birth:___/___/_____ Relation to patient: __________

Policyholder Address (if different): ____

Vision Insurance Information

Vision Insurance: _________________________________ Policyholder Name: ____________________________

Policyholder Social Security#:___________________ Date of Birth:___/___/_____ Relation to patient:__________

Financial Authorization

I hereby give consent to Mitchell Family Eye Care and/or any doctors at this location to provide eye care services to myself and/or to any party for which I am legally responsible. I understand that regardless of my insurance status, I am ultimately responsible for any charges incurred by me or by any party for which I am legally responsible.

Signed: ____ Date: __________________________

Information Authorization

I authorize use of this signature for all of my insurance submissions. I authorize payment of benefits directly to Mitchell Eye Care Associates and/or to my doctor. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

Signed: ____ Date: __________________________

How did you hear about our office?

☐Yellow pages ☐Internet ☐TV ☐Insurance company ☐Referred by _________ ☐Other: __________