WELCOME TO ALL SAINTS EYE CENTER

NAME: ____
Last First Middle Initial

GENDER: M____ F____ DATE OF BIRTH________________________ AGE: __________________

SOCIAL SECURITY #:________________________________ MARITAL STATUS: ___________________

LOCAL ADDRESS:

____
Street or PO Box City State Zip Code

HOME PHONE: (_____) ____________________________ WORK # :(____) _____________________________

I give permission to be contacted via E-Mail ☐ **E-Mail Address_______________________________________**

NORTHERN ADDRESS:

____
Street or PO Box City State Zip Code

NORTHERN PHONE :(_____) ____

EMPLOYER: ____________________________________ OCCUPATION: ______________________________

EMPLOYER ADDRESS: ____
Street or PO Box City State Zip Code

MEDICAL INSURANCE: PRIMARY__________________________ POLICY #_________________________

SECONDARY_______________________ POLICY #________________________

Guarantor Information (Person responsible for payment if different from self):

Name: ___________________________________ SSN_______________________ Birth Date______/_____/______

Address: ____ Relationship to Patient: ________________________

Employer: ____ Phone: (_____) _________________________

IN CASE OF EMERGENCY, PLEASE INDICATE SOMEONE WE MAY CONTACT OTHER THAN YOUR SPOUSE:

NAME: ____ PHONE (_____) __________________________________

RELATIONSHIP: ____

FAMILY DOCTOR: ______________________________ PHONE: (____) __________________________________

HOW DID YOU HEAR ABOUT OUR PRACTICE? ____
Newspaper, Radio, Yellow Pages, Television, Friend, Doctor, Other

PRIVATE INSURANCE PATIENTS: I understand that my doctor does not accept insurance assignment for payment of this medical bill. I agree to pay the doctor the full amount of his/her fee for service irrespective of my insurance allowance, insurance deductible or any denial by my carrier for uncovered services.

_________________________ ____
DATE **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**