## Family EyeCare Center -- Welcome to Our Office!

## PERSONAL INFORMATION

SERIOR SURJOYER NAME  AMBITAL STATUS  EMPLOYER ADDRESS  CITY, STATE, ZIP CODE  CELL PHONE #  CELL PH	NAME (LAST)		(FIRST)	(FIRST)		(MIDDLE)		NICKNAME		DATE OF BIRTH			
MARTAL STATUS  FMPLOVER ADDRESS  CITY, STATE, ZIP CODE  CELL PHONE #  PREVIOUS EYE DOCTOR  JOIN TO TEXT  JOIN THE JOIN TO TEXT	SOCIAL SECURITY		HOME ADDR	ESS		CITY, STATE, :		ZIP CODE		HOME PHONE #			
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Communication professores (please sizele ene):  Telephone Telephone Telephone	NOTE: all patie	ent informat	ion is kept <u>strictly</u>	confidential. Your a	address is NEV	ER shared.							
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## **SOCIAL HISTORY**

(Required to document according to federal guidelines)

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Height:	_ feet inches Weight: lb	s.
Do you use to	bacco products? [ ] No [ ] Yes If Yes, type:	amount: how long:
Do you drink a	llcohol? [ ] No [ ] Yes If Yes, type:	amount: how long:
		amount: how long:
	ant and / or nursing? [ ] No [ ] Yes	
Have you eve	been exposed to or infected with: [ ] Gonorrhea	[ ] Hepatitis [ ] HIV [ ] Syphilis Other:
	NON-CO	OVERED SERVICES
so I understa there will be	nd the additional charge will be my responsibility. If you	Most insurance companies do not cover contact lens related office visits, u are a new contact lens wearer or are being fit in a different type of contact lens, screening is not covered by insurance companies and if I choose to have that
Signature _		Date
Signature		
	INSURANCI	E SIGNATURE ON FILE
	MOOKANOI	E GIGNATURE ON TIEE
Patient N	lame (Print)	Medicare ID #
. Medicare	<b>;</b>	
me by Fa Administ I underst claim. If signature	amily EyeCare Center. I authorize any holder of ration and its agents any information needed to be and my signature requests that payment be mad other health insurance is indicated in Item 9 of the authorizes releasing the information to the insurance.	e made on my behalf to Family EyeCare Center for services furnished to medical information about me to release to the Health Care Financing be determine these benefits or the benefits payable to related services. The and authorizes release of medical information necessary to pay the see HCFA 1500 form or elsewhere on other approved claim forms, my rer or agency shown.  In of the Medicare carrier as the full charge, and the patient is responsible
only for t		vices. Coinsurance and the deductible are based upon the charge
Signatur	e of Patient, Parent or Legal Guardian	Date
. Medigap		
forms, m		in Item 9 of the HCFA 1500 form or elsewhere on other approved claim to the insurer or agency shown. I request that payment of authorized my behalf to Family EyeCare Center.
Signatur	e of Patient, Parent or Legal Guardian	Date
3. Other In	surance	
I authori: services	ze this office and the insurance company to relea and/or materials provided. In the event my deduc	office of Family EyeCare Center for any services or materials furnished. ase pertinent information so the benefits payable may be determined for the ctible has not been met, or my insurance company does not pay in full or sible for the account will be required to pay the balance.
Signatur	e of Patient, Parent or Legal Guardian	 Date