



Patient Information

Name: (Last) _____ (First) _____ (M) _____ Nickname:† _____

Gender: Male Female Birth Date: ___/___/___ Social Security #: _____

Address: _____ Home Phone: _____

Work/Other Phone: _____

Email Address: _____ Occupation: _____

If you do not want to receive emails, please check this box Employer: _____

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: _____