Welcome to the Eye Care Center!

Please PRINT

1 Patient Information

Last | First | Middle Initial | Title

Social Security Number | Date of Birth | Gender ☐ Female ☐ Male

Home Address | City | State | Zip

Race
☐ Caucasian / White ☐ African American ☐ Asian ☐ American Indian
☐ Hispanic / Latino ☐ Pacific Islander ☐ Other ☐ Decline to Answer

Preferred language if not English

How I Heard About the Eye Care Center

☐My Doctor or Health Practitioner (complete this section) Skip section if: ☐Family/Friend ☐Mailing ☐Newspaper/Magazine ☐Internet ☐Walk-in

Last | First | Middle Initial | Degree

Business Address | City | State | Zip | Phone

2 Contact Information

Preferred Phone ☐Home ☐Work ☐Cell | 2nd Phone ☐Home ☐Work ☐Cell | 3rd Phone ☐Home ☐Work ☐Cell

Email

☐ Yes, please send me periodic emails with special information or offers. (Your email is never sold or used for other purposes.)

3 Responsible Party / Parent / Guarantor

Relationship to Patient ☐Self (skip this section) ☐Spouse ☐Parent ☐Other__________

Last | First | Middle Initial | Title

Social Security Number | Date of Birth | Gender ☐ Female ☐ Male

Home Address ☐Same as Patient's | City | State | Zip

I authorize the Eye Care Center to treat/care for this child under the general supervision of any staff optometrist. This consent is given pursuant to the provisions of section 25.8 of the Civil Code of California.

Signature ____Date ____________

4 Insurance Information

Present your insurance card(s) to the receptionist

Name on Policy ☐Same as #1 (fill out employer info. only) ☐Same as #3 (fill out employer info. only) ☐Other (complete entire section)

Last | First | Middle Initial

Social Security Number | Date of Birth | Gender ☐ Female ☐ Male

Employer Name | Employer Address | Employer Phone

5 In Case of Emergency Contact Information

☐ Same as 3 (skip this section)

Last | First | Relationship to Patient

Home Address | City | State | Zip

Preferred Phone ☐Home ☐Work ☐Cell | 2nd Phone ☐Home ☐Work ☐Cell | 3rd Phone ☐Home ☐Work ☐Cell

6 Financial Policy Acknowledgement (gold form)

The Eye Care Center accepts cash, checks, Visa, MC, and Discover

*I have read the **Eye Care Center Financial Policy** (gold form) and agree to the policies stated therein. I understand that I am financially responsible for charges when services are rendered. If my insurance is billed I am responsible for services, material, or deductibles not covered, and I authorize the Eye Care Center to release medical information necessary to my insurance company to process claims submitted on my behalf.*

Signature ____Date ____________

7 Privacy Rights Acknowledgement (green form)

*I have read the **Eye Care Center Privacy Notice** (green form) and understand my rights contained therein. By way of my signature, I acknowledge that the Eye Care Center has provided me with a policy regarding the use and disclosure of my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. A copy shall be as valid as the original.*

Signature ____Date ____________