All Things Eyes
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Patient Information Form

Name (Last, First):	Preferred Name:	DOB:
Address:	APT/Unit#	City, State, Zip:
Marital Status:	SSN:	Gender:
Employer:	Occupation:	
Contact Phone #:	E-Mail:	
If mobile # is provided, may we text you?		
Are you a new or existing patient?	How did you hear about our office?	

We respect your privacy. Any contact information given to our office will never be shared with any unauthorized parties. However, we may contact you for appointments, order status, questions and any other reasons.

Primary **VISION** Insurance:	Insured Date of Birth:
Insured First Name:	Insured Last Name:
Insured SSN:	Relationship to Patient:
Insurance ID #:	

Primary **MEDICAL** Insurance:	Insured Date of Birth:
Insured First Name:	Insured Last Name:
Insured SSN:	Relationship to Patient:
Insurance ID #:	

I, the patient, acknowledge that: **(1)** I have provided correct information for the Patient Information Form, and
(2) I understood any attached forms, including the Notice of Privacy Practices (HIPAA), Advance Beneficiary Notice (ABN) and Office Return Policy. **(3**) Appointments that are not cancelled or rescheduled within 24 hours of your appointment are subject to a **$25 fee**: This will not be covered by your insurance.
All fees are due on the day of service.

Print Name: ____

Signature: ____ Date: __________________

(Parent or Guardian signature, if under 18 years old)