ADVANCED EYE CARE ASSOCIATES

NAME: Last _____ First _____ MI _____

Date of Birth: _____/_____/_____ Social Security _____/_____/_____ Male / Female

Race: (circle all that apply) Indian/African American/Asian/White/Other _____

Ethnicity: Hispanic/Non-Hispanic Preferred Language_____

Marital Status: Single/Married/Divorced/Widowed Email: _____

Address: _____Apt # _____

City: _____ State: _____ Zip: _____

Home # (____) _____ Cell # (____) _____ Work # (___) _____

Occupation: _____ Employer: _____

Primary Care Physician _____ Phone# _____

PRIMARY INSURANCE

Insurance Company: _____ ID# _____

Policy Holder Name: _____ Date of Birth: ____/____/____

Social Security _____/_____/_____ Relationship to patient: _____

GENERAL OFFICE POLICIES

I hereby authorize Advanced Eye Care Associates, to apply for benefits on my behalf for the services I have received and to release any pertinent medical information to my insurance carrier listed above. I certify that the insurance information that I have provided is accurate. I understand that I may be responsible for any services that are not covered by my insurance or services applied toward a deductible and/or co-insurance.

Signature: _____ Date _____