ACCESS EYE

STAY FOCUSED

We appreciate your time and ask that you update your information on paper

with our office every three years or if there are any changes in your information.

Patient Name (Last, First, Middle) _____

SSN#	Birthdate	Ethnicity Hispanic/Latino Not Hispanic/Latino
Sex M / F	Marital Status	Race
Language	Cell Phone	Home Phone
Email Address		
Local Address		
City, State, Zip Code		
Billing Address (if different than above)		
City, State, Zip Code		
Emergency Contact Name and Contact Number		
Primary Care Physician		
Smoker Yes No	Student Yes No	Veteran Yes No
Employer Information **(patient or responsible party)**		
Employer Name (of patient or responsible party)		
Employer Address		
City, State, Zip Code		
Employer Phone Number		

Responsible Party	Name (Last, First, Middle)	
SSN#	Birthdate	Ethnicity Hispanic/Latino Not Hispanic/Latino
Sex M / F	Marital Status	Race
Language	Home Phone	Day Phone
Email Address		
Local Address		
City, State, Zip Code		
Billing Address (if different than above)		
City, State, Zip Code		
Primary Medical	Name of Insurance	
Name of Insured		Insured's Date of Birth
Relationship to Patient	Policy Number	Group Number
Secondary Medical	Name of Insurance	
Name of Insured		Insured's Date of Birth
Relationship to Patient	Policy Number	Group Number
Third Insurance or Vision Insurance	Name of Insurance	
Name of Insured		Insured's Date of Birth
Relationship to Patient	Policy Number	Group Number

I certify that I have filled out the above information to the best of my knowledge. If my insurance requires a referral I understand it is my responsibility to have one at the time of service. I understand if I do not provide a referral I will be responsible for the services provided at the time of service.

Signature of Patient/Guardian Date

_____ _____