DOVER EYE CARE PATIENT INFORMATION SHEET

DATE: ___/___/_____

NAME: MR / MRS / MS / DR _____

DATE OF BIRTH: ___/___/_____ AGE: _____

SOCIAL SECURITY # _____-_____-_____ SEX: MALE / FEMALE

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: (H) ____-____-_____ (C) ____-____-_____ (W) ____-____-_____

E-MAIL ADDRESS: _____ @ _____

PREFERRED METHOD OF CONTACT: PHONE E-MAIL TEXT MESSAGE

MARITAL STATUS: SINGLE MARRIED/PARTNERED WIDOWED DIVORCED

OCCUPATION: _____ EMPLOYER: _____

PRIMARY CARE PHYSICIAN: _____

PREFERRED PHARMACY: _____

PERSON RESPONSIBLE FOR BILL (GUARANTOR): _____

INSURANCE

DOVER EYE CARE WILL SUBMIT YOUR CLAIM TO INSURANCES THAT WE CONTRACT WITH. PLEASE PRESENT YOUR CARD TO THE RECEPTIONIST.

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS.

PATIENT SIGNATURE: _____

NOTE: IF YOU ARE **NOT** THE PRIMARY SUBSRIBER OF YOUR INSURANCE, PLEASE PROVIDE THE FOLLOWING:

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: ___/___/_____ RELATIONSHIP TO YOU: _____

SUBSCRIBER SOCIAL SECURITY # (LAST 4 DIGITS ONLY) _____