**Northwest Eye Center, P.C.**

WELCOME TO OUR OFFICE

**Patient Information** **Today's Date:** _____

Patient Last Name_____ First Name _____MI_____

Nickname _____Male _____Female_____ Marital Status: M D S W LS

Address: _____ City: _____State: _____ Zip: _____

Primary # Home/Work/Cell_____Secondary # H W C _____ Third # H W C _____

Date of Birth: _____ Social Security: _____

Employer: _____ Occupation: _____

Whom should we thank for referring you? _____

Name of closest relative not living with you: _____ Relationship: _____ Phone:_____

**Policy Holder/Responsible Party:** _____
(Must be filled out if under 18)

******PLEASE PRESENT ALL INSURANCE CARDS FOR ACCURATE BILLING******

**MEDICAL INSURANCE**

Policy Holder Name _____MI _____ Last Name_____

Relationship to patient: _____ Social Security: _____Date of Birth: _____

Address if different from patient: _____ Phone: _____

Insurance Company: _____ Employer: _____

Policy #: _____ Group # : _____

**VISION INSURANCE**

Insurance Company: _____Phone: _____

Policy # /SSN# _____Group # : _____

**SECONDARY INSURANCE**

Policy Holder Name _____ MI _____ Last Name _____

Relationship to patient: _____ Social Security: _____Date of Birth: _____

Address if different from patient: _____ Phone: _____

Insurance Company: _____ Employer: _____

Policy #: _____ Group # : _____

I authorize the release of any information concerning my (or my child's) healthcare to expedite insurance payment. I also hereby authorize payment of insurance and understand that I am responsible for all chargers, regardless of insurance coverage.

X_____

**Would you like to be contacted by Phone, E-Mail or Text?** _____

**E-Mail address:** _____