Eyemax Vision Center

Patient Name:		Referred By:	
Address:		Date of Birth:	
City: State: Zip:		Social Security No.	
Home Phone: Y/N Primary Work Phone:	Cell Phone:	Primary Y/N	
E-mail Address:			
Race (please circle): White Black Asian Indian/Alaskan Pac. Isle	Other/Multi:		
Ethnicity (please circle): Hispanic Non-Hispanic **Language:**			
Patient's Employer:			
Employer's Address:			
Spouse's Employer:			
Responsible Party: Relationship:			

INSURANCE INFORMATION

PRIMARY Insurance Company	Contract Number
Policy Holder Name	Group Number
SECONDARY Insurance Company (If applicable)	Contract Number
Policy Holder Name	Group Number
If insurance is PPO, what is the copay amount? $	
Are you Retired? Yes No	
Are you being seen here by a doctor's referral?	

We request payment at the time of service. You will be given an itemized statement for insurance purposes. If we participate in your insurance plan, you must pay your copayment and / or deductible at the time of service. We do participate with Medicare. I give my permission to release any and/ or all information in my chart necessary to process my insurance claims.

Signature of Patient or Responsible Party	Date