PATIENT INFORMATION
NEW PATIENT-PLEASE PRINT

CHART #: **Date: _____**

Last Name:		First Name:	
Home Address:	City:	State:	Zip Code:
SSN :		DOB:	
Gender:		Marital Status:	☐ Married ☐ Single ☐ Divorced ☐ Widow
Home Phone:		Cell phone:	
Employer		Occupation:	
Work Phone:			
Emergency Contact (other than spouse)		Phone Number:	

Preference of appointment reminder: ☐ **Phone** ☐ **Text** ☐ **Email**

Email Address: _____

Please indicate how our heard about us: ☐ Internet: www. _____

☐ Dr. _____ ☐ Friend ☐Newspaper ☐ Yellow Pages ☐ Other

RESPONSIBLE PARTY

Are you, the patient, and the responsible party for this account?	☐ Yes ☐ No

***If someone other than the patient is responsible for this account please provide their information.*

Last Name:		First Name:			
Street Address:					
City:		State:		Zip:	
Home Phone:		Work Phone:		Cell Phone:	

****PRIMARY INSURANCE INFORMATION****

Primary Insurance:			
ID Number:		Group Number:	
Subscriber:			
Insured's Date of Birth:		Relation to Insured:	
Employer		Work Phone:	
Address:			

****SECONDARY INSURANCE INFORMATION****

Secondary Insurance:			
ID Number:		Group Number:	
Subscriber:			
Insured's Date of Birth:		Relation to Insured:	
Employer:		Phone Number:	
Address:			

I hereby authorize my insurance company to pay directly to Focal Point Vision Correction, all benefits otherwise payable to me under the provisions of my policy. I hereby authorize the necessary medical information to be released to the insurance company for processing this claim and to be released to physicians or optometrists in connection with the continuity of care of patient. Photostat copies of this authorization will be considered as valid as the original.

Patient Signature: _____Today's Date: _____

Revised 09/04/2013