Family Eye Care West.
Welcome To Our Office

Welcome to Family Eye Care West.. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Work Phone _____

Email Address _____ Spouse or Parent(s) Name _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

	ft	in	cm/m	
Height				○ ft in ○ cm ○ m
Weight				○ lbs ○ kg

Race

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ Other Race
- ☐ White
- ☐ Native American
- ☐ Caucasian
- ☐ Refuse To Specify
- ☐ Not Disclosed

Other Race _____

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

How were you referred to our office?

- ☐ Phone Book
- ☐ School
- ☐ Advertisement
- ☐ Patient (Please Name) _____
- ☐ Insurance Listing
- ☐ Drive by
- ☐ Other _____
- ☐ Doctor (Please Name) _____

Patient has received HIPAA Privacy Policy? ○ Yes ○ No **Date** _____

Notes _____

Name

Family Eye Care West.

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State | Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature

Date