PRIMARY EYE CARE ASSOCIATE, P.C.

Patient's legal name(Mr. Mrs. Dr. Ms.)_____

Birthdate_____ Social Security#_____

Address_____ City_____ Zip Code_____

Home Phone_____ Work Phone_____

Employer_____ Referred By_____

Person responsible for account_____ Same as above ☐

Birthdate_____ Social Security #_____ Employer_____

***Medical* Insurance_____ Subscriber's Name_____**

Birthdate_____ Social Security #_____ Relationship to patient_____

***Vision* Insurance_____ Cardholder's Name_____**

If the information below is the same as medical insurance please check here_____

Birthdate_____ Social Security #_____ Relationship to patient_____

Payment Policy: Payment for professional services is required at the time of service. If ophthalmic materials are ordered a non-refundable deposit is required as all materials are custom made to your prescription. The balance is due at the time of dispensing. If insurance is used to pay for services you will be responsible for any fees not covered by your insurance. It is your responsibility to know your benefits. We cannot be held responsible for knowing this information. Your contract for coverage is between you and your insurance company.

I understand and agree with the above statement:_____ _____
Signature of patient or parent/guardian if patient is a minor Date

May we contact you by E-mail for appointment reminders or status of your material orders? If so please leave your e-mail address.
E-mail:_____
Your e-mail will only be used by our office employees to communicate with you and will not be shared with anyone outside of the office.