KENT STATION VISION CLINIC

NEW PATIENT INFORMATION FORM

Patient Information

Name: ______________________ Date: ____________

Address: ______________________ City, State, Zip: ____________

Social Sec #: ____________ Birthdate: ____________ Age: ____________

Hm phone: ____________ Wk phone ____________ cell/pager ____________

Marital Status: Single Married Divorced Widowed E Mail: ____________

Occupation: ____________ Hobbies: ____________

Person to contact in case of emergency: ____________ Phone # ____________

Whom may we thank for referring you to us? ____________

If you are a student, name of school/college: ____________ City: ____________

Responsible Party **if different from above**

Name of person responsible for account if not the patient: ____________

Address: ____________ City, State, Zip: ____________

Hm phone: ____________ Wk phone: ____________ cell/pager ____________

Employer: ____________ Relationship to patient: ____________

Insurance Information

Insurance: ____________ Group # ____________

Subscriber: ____________ ID # ____________

Patient's relationship to subscriber: Self Spouse Child Dependent

Subscriber's employer: ____________ Subscriber's date of birth: ____________

If we are billing your insurance for you, please read and sign below

I acknowledge that I have completed all of the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third party payers and/or other health practitioners if needed. If insurance is to be billed, I understand that this is a courtesy provided by the eye doctors office, and authorize my insurance company to directly pay the office. I understand that my insurance company may not cover the actual amount for services and materials, and agree to be responsible for payment of any deductible amount, co-insurance or any balance not paid by the insurnace company. Lastly, I understand that returns &/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refunds will be given.

X ______________________ Date: ____________

If we are NOT providers with your insurance company or you are NOT USING INSURANCE, please read and sign

I authorize permission to treat my condition. I am financially responsible for all services at the time they are rendered. As a convenience, I will be provided with a superbill for which I may submit myself to my insurance company.

I understand that returns &/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refunds will be given.

X ______________________ Date: ____________

Please turn over and complete other side