EYEBRIGHT
OPTOMETRY

Welcome to Eyebright Optometry!

Date:_____
Name: Miss / Mrs. / Ms. / Mr. / Dr. _____

Address_____City, State, Zip_____

Cell Phone_____ Home/Work_____

Email _____.com

Preferred method of appointment reminders: Mail / email / Phone

Employer_____ Occupation_____

SSN _____-_____-_____ **DOB** _____-_____-_____

Vision Insurance: Are you the primary for the account? Yes or No, if No please list

Primary member name_____ DOB _____-_____-_____

Primary member SSN_____-_____-_____ relationship to you_____

Check all that apply
☐ Davis ☐ EyeMed ☐ Medicare ☐ MES ☐ Superior ☐ VSP
☐ None ☐ Other_____

Medical Insurance Plan:_____ID# _____

Group #_____Member name (if not yourself)_____ DOB____-____-_____

Emergency Contact_____ Emergency Phone_____

How did you hear about our office? (Check all that apply)

☐ Insurance Listing	☐ Yelp	☐ Patient referral _____
☐ Driving by	☐ Office website	☐ Doctor_____
☐ Walk-in		☐ Other _____

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) Please Initial/sign

_____ (initial) I have been provided a copy of Eyebright Optometry Notice of Privacy Policy and understand I may request a copy for my records. The Notice of Privacy Practices is subject to change.

_____ (initial) I authorize the payment of health care benefits to this office. I understand I am responsible for payment of any charges not covered by insurance.

_____ (initial) I authorize any holder of medical information about me to be released and/ or request my medical information with other health care professionals for the purpose of consultation and referral as needed for my health care.

Signature: _____

Please print name if signing for a minor_____