## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security #: _____ Birth Date:_____

Phone (Home): _____(Work): _____Ext: _____ (Cell)_____

Address: _____
Street City State Zip Code

Email Address: _____ Emergency Contact_____

How did you hear about us?_____ Family Doctor_____Phone_____

## Spouse, Responsible Party, or Policy Holder Information

(Divorced parents: It is the policy of this office that the parent accompanying the child for treatment will be held responsible for all bills-we can not bill the other parent)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street City State Zip

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
Street City State Zip Code

## Insurance Information

***Please present all insurance cards, including medical and routine vision coverage, to the registration desk.**

## Refraction

A refraction is the test to determine your glasses prescription or refractive error. Most insurance companies do not pay for this service. You may be responsible for the $40.00, in addition to any Co-pay, Co-Insurance, or Deductibles that you will pay upon check-out.

_____ _____
Signature of patient, parent or guardian date

## Consent for Services

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plan to: Eye Consultants of Kentucky, P.S.C. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____
Signature of patient, parent or guardian