

# Eye Care Arkansas, P.A.

Today's date \_\_\_\_\_

Patient First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Social Security # \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male Female

Marital Status: D M S W Employment Status: Full Part Retired Student

Patient's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Other phone (cell/pager) \_\_\_\_\_

Patient or Parent's employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse or Parent's name \_\_\_\_\_

Emergency contact name and phone # \_\_\_\_\_

Referring or Primary Care doctor and phone # \_\_\_\_\_

Responsible party (if patient is a minor)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work phone \_\_\_\_\_

**We require the following information in order to file your insurance. If this information is incorrect, the balance will be your responsibility.**

**Insurance Information—Please read—Payment in full for your visit is your responsibility. In order for us to involve your insurance company in the payment process we must have the correct information.**

**Primary Medical Insurance** \_\_\_\_\_ ID# \_\_\_\_\_

Address \_\_\_\_\_

Insured's name, SSN and Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**Secondary Medical Insurance** \_\_\_\_\_ ID# \_\_\_\_\_

Address \_\_\_\_\_

Insured's name, SSN and Date of Birth \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Vision Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Group Name \_\_\_\_\_

Insured's Name and Date of Birth \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Please Read the following, then sign and date below:

I authorize payment of medical benefits from my insurance company to be made to Eye Care Arkansas, P.A. or Eye Care Optical, LLC. I authorized release of the medical information needed to my insurance company in order to process these claims. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE COMPANY.**

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_