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Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ ext. _____ Cell #: _____

E-Mail: _____ May we send you a text? ☐ Yes ☐ No

Gender: ☐ Male ☐ Female Are you a full time student? ☐ Yes ☐ No

Date of Birth: _____ Age: _____ SSN#: _____ Marital Status: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you? _____ ☐ Google search ☐ Website ☐ Ad

Personal Interests (hobbies, etc.): _____

Emergency Contact: _____ Phone Number(s): _____

INSURANCE INFORMATION

Vision insurance name: _____ Name of policy holder: _____

SSN# of policy holder: _____ Birthdate of policy holder: _____

Occupation and employer of policy holder: _____

Medical insurance name: _____ Name of policy holder: _____

SSN# of policy holder: _____ Birthdate of policy holder: _____

Policy ID# _____

Primary Care Physician: _____ Phone #: _____

ASSIGNMENT AND RECORDS RELEASE CONSENT

I have read and understood the Notice of Privacy Practices. I certify that my dependant or myself has insurance and assign directly to 4S Eyecare & Optometry all insurance benefits, if any, otherwise payable to me for services rendered. Insurance estimates are a courtesy. In the event that I do not have current insurance benefits or I am a cash-paying patient, **I am financially responsible for all charges not covered by insurance**. I hereby authorize the doctors to release all information necessary to secure the payment of insurance benefits. I authorize this signature on all insurance submissions. I give consent to 4S Eyecare & Opomtetry to release any medical records for the above-specified individual to the insurance provider and/or co-managed practitioner should it be necessary.

Signature: _____ Date: _____ Relationship to patient: _____

PERSONAL HEALTH HISTORY:

Medications, Vitamins or Supplements: (List all) _____

_____

Are you allergic to any medications? (List all) _____