EYEBRIGHT
OPTOMETRY

Welcome to Eyebright Optometry!
Thank you for choosing us for your eye care needs.
Please take a moment to complete the following form. If you have any questions do not hesitate to ask.

Name: Miss Mrs. Ms. Mr.				
Address			Home	Cell
City	State	Zip	Work	Email
DOB	SSN		Employer	
Person Responsible for Account				Relationship
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 _____				
Vision Insurance: ☐ EyeMed ☐ Davis ☐ Medi-cal ☐ Medicare ☐ MES ☐ Superior ☐ Spectra ☐ VSP ☐ None ☐ Other_____				
Members information if not your own: Name: DOB SSN Employer Patient relation to insured Spouse/Child/Other_____				
Medical Insurance Plan:				

*PLEASE SIGN **BOTH** lines.*

Authorization of Benefits

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.

Signature: _____ Date: _____
Patient or Guardian

HIPAA Notice of Privacy Practices from Eyebright Optometry.

The Notice of Privacy Practices is subject to change. Updated policies will be available at the front desk.

I acknowledge I have received/and or read Eyebright Optometry Notice of Privacy Policy.

Signature: _____ Date: _____
Patient or Guardian