Welcome to Eyebright Optometry!

Name _____ Date of Birth _____

Address _____

Phone number _____

Email _____.com

Preferred method of appointment reminders: Mail / email / Phone

Employer_____ Occupation_____

Last 4 of SSN _____

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

Primary member name_____ DOB _____-_____-_____

Primary member last 4 SSN _____ relationship to you_____

Check all that apply
☐ Davis ☐ EyeMed ☐ Spectera ☐ Medicare ☐ 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. Updated policies will be available at the front desk.

_____ (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: _____ Date _____

Please print guardian's name if signing for a minor _____