Family Vision Center

Theresa J. Haas, O.D. • Jeremy T. Nett, O.D.

Patient Information Form

Please fill in ALL blanks.

	Patient:_____ Adult _____ Child	_____ Parent _____ Significant Other	Other Parent (If applicable)
Last Name			
First Name			
Middle Name			
Date of Birth			
Address			
City			
State & Zip Code			
Home Phone #			
Cell Phone #			
Social Security #			
Employer			
Work Phone #			
Email address:			
Patient Status: Single____ Married____ Divorced____ Widowed____			
Heard about our office from: Physician_____ Phone Book_____ Friend____ Other____			

EMERGENCY CONTACT (other than listed above)
Name_____ Phone No._____
Relationship to patient_____

	INSURANCE CO. #1	**INSURANCE CO. #2**
Insurance Company Name		
Name of Insured/ Date of Birth		
Policy # or S.S. # of insured		
Group # (if any)		

Insurance Signature on File

I certify that the information given by me in applying for insurance and /or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Family Vision Center on my behalf for any services and materials furnished. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer and authorizes my doctor to act as my agent as above. I understand charges not covered by insurance are the patient's responsibility. I have also read and understood Family Vision Center's financial policy.

Signature_____ Date_____
Patient/legal guardian

Updated (initials):_____ Date_____ Update (initials):_____ Date_____

Updated (initials):_____ Date_____ Update (initials):_____ Date_____

Please continue on back side…