PATIENT INFORMATION

Today's Date:_____How did you hear about us:_____
Last Name:_____ First Name:_____MI:_____
Address:_____City:_____State:_____Zip:_____
DOB:_____ SS#_____
Cell number:_____ Sex _____MALE _____FEMALE _____OTHER
Race:_____ Asian_____ African American____ Hispanic ____Caucasian/NonHispanic
Preferred language:_____ English _____ Spanish _____Other
Date of last eye exam:_____Name of last eye doctor:_____
Date of last physical exam:_____Name of primary care physician:_____
Marital status:_____Employer:_____
Occupation:_____Height_____ Weight_____lbs.
Parent/guardian: Name_____ Relationship to patient:_____
Emergency Contact: Name_____Phone number:_____
Relationship to patient:_____
IF YOU WISH US TO BILL AN INSURANCE COMPANY FOR YOU, THE FOLLOWING INFORMATION IS REQUIRED (Failure to supply the required information, will result in patient being billed for the visit in full at time of service)

MEDICAL INSURANCE

Medical Insurance:_____Policy holder's Name:_____
Policy holder's SS#_____ Policy holder's DOB:_____
Policy holder's Employer:_____ Occupation:_____
Relationship to policyholder: SELF SPOUSE/DOMESTIC PARTNER CHILD
Policy holder's address if different from patient:_____

VISION INSURANCE

Vision Insurance:_____Policy holder's Name:_____
Policy holder's SS#_____Policy holder's DOB:_____
Policy holder's Employer:_____ Occupation:_____
Relationship to policyholder: SELF SPOUSE/DOMESTIC PARTNER CHILD

- **Payment is due when services are provided. We accept cash, Visa, Discover, Amex and Mastercard, please ask for details.**
- **You are responsible at time of visit for any: CO-PAYMENT, CONTACT LENS FITTING FEE, VISUAL FIELD EXAM FEE AND FEES FOR EYEGLASSES; all fees will be discussed with you prior to you receiving services.**

I authorize Jamesburg Family Eyecare and Dr. Magdalena Spiewak to perform all necessary tests to ensure proper diagnosis and treatment of any eye condition. I also authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I realize that insurance information and benefits must be presented and verified at the time of the service. We cannot refund you for insurance benefits that were not verified or available at the time of the service date.

Signature of Patient/Parent/Guardian Date

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