EYE CARE ASSOCIATES - PATIENT PROFILE

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ SOCIAL SECURITY NUMBER: _____

CITY, STATE _____ ZIP _____ MALE _____ FEMALE _____

PHONE: _____(Home) _____ (Work) ___MARRIED ___ SINGLE ___ DIVORCED ___ OTHER

EMPLOYER: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____

GUARANTOR: (Person responsible for payment of bill) ____ Same as patient

NAME: _____ EMPLOYER: _____

ADDRESS: _____ EMPLOYER PHONE: _____

CITY, STATE _____ZIP _____ HOME PHONE: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____/_____/_____

PRIMARY INSURANCE: ____Same as Patient ____Same as Guarantor ____ Other

INSURED PARTY NAME: _____ RELATIONSHIP TO PATIENT: _____

INSURED PARTY PHONE: _____ SOCIAL SECURITY NUMBER: _____

INSURANCE COMPANY: _____ DATE OF BIRTH: _____/_____/_____

INSURED ID NUMBER: _____ POLICY GROUP: _____

SECONDARY INSURANCE: ____Same as Patient ____Same as Guarantor ____ Other

INSURED PARTY NAME: _____ RELATIONSHIP TO PATIENT: _____

INSURED PARTY PHONE: _____ SOCIAL SECURITY NUMBER: _____

COMPANY: _____ DATE OF BIRTH: _____/_____/_____

INSURED ID NUMBER: _____ POLICY GROUP: _____

PLEASE TURN THIS SHEET OVER FOR FINANCIAL RESPONSIBILITY, INSURANCE INFORMATION AND SIGNATURE.