

**Please use Black Ink only to fill out forms.**

Male  Female  Please check this box if you are a winter visitor. If so, please provide both addresses.

MR./MRS./MS. **LEGAL NAME:** \_\_\_\_\_  
(Please Circle One) LAST FIRST MI SPOUSE

LOCAL ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE **9 DIGIT ZIP**

MAILING ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE **9 DIGIT ZIP**

Home Phone: ( ) Cell Phone: ( ) Alternate: ( )  
 Work  Day  Other

**E-MAIL ADDRESS:** \_\_\_\_\_ We do NOT share this information with anyone. E-mail is a way for your doctor to communicate with you, to receive information about your procedure and to send reminders.

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_ PHONE: ( ) RELATIONSHIP: \_\_\_\_\_

NAME & ADDRESS OF EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: ( )  
(Not in the same household.)

**MEDICAL INFORMATION: WHO IS YOUR MEDICAL DOCTOR?** \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: ( )

**INSURANCE INFORMATION**

PRIMARY INSURANCE: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

GROUP# \_\_\_\_\_ POLICY # \_\_\_\_\_ D.O.B. \_\_\_\_\_

PRIMARY ADDRESS \_\_\_\_\_ INSURANCE PHONE: ( )

SECONDARY INSURANCE: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_

GROUP# \_\_\_\_\_ POLICY # \_\_\_\_\_ D.O.B. \_\_\_\_\_

SECONDARY ADDRESS \_\_\_\_\_ INSURANCE PHONE: ( )

**AUTHORIZATION AND RELEASE**

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company and/or Medicare to pay directly to the doctor or doctor's group insurance or Medicare benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that I will be billed a fee for any returned checks.

\_\_\_\_\_  
Signature of patient or parent, if minor Date Signature of witness

**PLEASE NOTE: MOST INSURANCE POLICIES DO NOT COVER REFRACTION SERVICES.**

**HOW WERE YOU REFERRED TO OUR OFFICE?**

DOCTOR (NAME: \_\_\_\_\_)  FRIEND/RELATIVE (NAME: \_\_\_\_\_)  
 NEWSPAPER  RADIO/TELEVISION  SCREENING  YELLOW PAGES  REPUTATION  
 OTHER \_\_\_\_\_

VISIT OUR WEBSITE AT [www.goodeyes.com](http://www.goodeyes.com)