

Welcome to: CENTRAL PHOENIX EYE CARE

Please fill out completely: **Date** ____/____/____

Patient Name: _____

(__Mr / __Mrs / __Miss / __Ms / __Dr) **Last** **First** **MI**

If patient is a child: Mother's name _____ **Father's Name** _____

Address: _____ **Apt#** _____

City: _____ **State:** _____ **Zip:** _____

Phone (Circle) 602 623 480 **(Circle)** 602 623 480 **(Circle)** 602 623 480

#'s: _____

HOME **WORK** ext _____ **CELL / PAGER**

Employer: _____ **OK to text:** __Yes __No

SS#: _____ **Birthdate:** ____/____/____ **Gender:** __Male __Female

e-mail: _____

Person Insured: _____ **Birthdate:** ____/____/____

Member ID# / SS# (if different from above) _____

RELATIONSHIP TO INSURED : __Self / __Spouse / __Child / __Other **(please check)**

Spouse's name _____

Whom may we thank for referring you to our office? _____

Vision Insurance: (Please check one if applicable):

None VSP HealthNet VCD Medicare VCP EYEMED BC/BS

Other _____

Payment Policy: Payment is required at the time services are provided. We do not accept assignments on insurance other than what is listed above or other medical plans for which we are participating providers. If your insurance plan is not listed above, please ask the receptionist if we are a participating provider. All deductibles, co-pays, lens or frame overages, etc, are due before any materials can be ordered.

At each visit to our office we will ask you if any of the above information has changed. We know that it may become repetitive, but we are only trying to keep your information as current as possible. As people change jobs, or as insurance anniversaries change, there may be a change in the information that we need to process your insurance benefits for you. So if we seem to ask you the same questions over and over again, please excuse us.

Thank you,

The staff of Central Phoenix Eye Care

(History form.pub/ 06/2010)