WELCOME TO FISHERS EYE CARE, LLC

ALL INFORMATION WILL BE HELD IN STRICTEST CONFIDENCE

PATIENT INFORMATION DATE_____

PATIENT NAME_____DATE OF BIRTH_____ MALE FEMALE

ADDRESS_____CITY,ST_____ZIP_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

SOCIAL SECURITY #_____E-MAIL ADDRESS_____

OCCUPATION_____EMPLOYER_____

EMERGENCY CONTACT FOR PATIENT_____

GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

NAME_____DATE OF BIRTH_____ MALE FEMALE

SOCIAL SECURITY #_____E-MAIL ADDRESS_____

EMPLOYER_____WORK PHONE_____

SPOUSE'S NAME_____DATE OF BIRTH_____SOCIAL SECURITY #_____

SPOUSE'S EMPLOYER_____WORK PHONE_____

VISION INSURANCE CARRIER_____POLICY #_____

MEDICAL INSURANCE CARRIER_____POLICY #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

I authorize Fishers Eye Care, LLC, to furnish the necessary care for my condition and understand that no guarantees as to the result of treatment have been made to me. I understand I am financially responsible for all charges whether or not paid by insurance. Payment/copayments are due at the time of service.

If the patient is a minor, I certify I am the legal parent/guardian and consent to treatment on their behalf.

_____DATE_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN