SOUTHERN EYECARE ASSOCIATES

WELCOME TO OUR OFFICE

Please complete the following

Date: _____

Patient Information

PLEASE PRINT

(Last) (First) (M.I.)

Patient:_____

Name you prefer to be called:_____

Address:_____**Apt #**_____

_____

City **State** **Zip**

Home ( )_____ **Work ( )**_____

Cell Phone ( )_____**Texting OK: Yes No**

Email _____

Sex: F M Age_____ **DOB** _____/_____/_____

Marital Status: Single Married Divorced Widowed

Spouse's Name _____

Race (Select one or more)

_____ American Indian or Alaska Native

_____ Asian

_____ Black or African American

_____ Hispanic or Latino

_____ Native Hawaiian or Other Pacific Islander

_____ White _____ Decline to answer

Ethnicity

_____ Hispanic or Latino

_____ Not Hispanic or Latino

_____ Decline to answer

Preferred Language _____

Patient SS# _____

(For Insurance Purposes only)

Occupation _____

Employer _____

IN CASE OF EMERGENCY, CONTACT

Name: _____

Relationship: _____

Home # _____ **Work #** _____

Cell# _____

Responsible Party Information

Name: _____

Relationship: _____

Address: _____

_____

City **State** **Zip**

Home ( )_____ **Work ( )**_____

SS #: _____ **Date of Birth:** _____/_____/____

(For Insurance Purposes Only)

INSURANCE

Primary Insurance:_____

ID#:_____ **Subscriber DOB:**_____

Subscriber Name:_____

Subscriber SS #_____

Secondary Insurance:_____

ID#:_____ **Subscriber DOB:**_____

Subscriber Name:_____

Subscriber SS #_____

How did you hear about our office? (Circle One)

Family Member/Friend	Facebook	Doctor Referral
Office Website	Newspaper	Insurance Carrier
Location	Internet Seach	Yellow Pages

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

I hereby authorize any necessary treatment by the Optometrists in the practice of Drs. Seipel and Dragon and further authorize Drs. Seipel and Dragon to file a claim with my insurance (s) providing I have coverage for the services rendered. I understand that I am responsible for my bill and any collection fees made necessary to collect payment of services and/or products provided in the event that I do not have the required coverage or the insurance claim is denied. I further authorize the office of Drs Seipel and Dragon to release or obtain any required medical information from my attending physicians or any medical facility.

My copay for a routine vision exam is:_____. My copay for a specialist medical exam is: _____

COPAYS ARE DUE AT THE TIME OF SERVICE

Patient Signature _____

(If MINOR, a parent/guardian MUST sign)

Date_____