



WELCOME TO OUR OFFICE !

Patient Information

name _____ date of birth _____
 address _____ occupation _____
 city, state, zip _____ employer _____
 home phone # _____ social security # _____
 work phone # _____ e-mail address _____
 spouse (or parent) _____ family members who are patients here: _____
 phone # (if different) _____

* * * * *

Insurance Information:

medical ins. company _____ **vision ins. company** _____
 subscriber's name _____ subscriber's name _____
 group # _____ group # _____
 subscriber's ID # _____ subscriber's ID# _____

* * * * *

I was referred by:

- friend or relative's name _____ insurance plan
- doctor's name _____ phonebook
- family member who is already a patient _____ other

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Payment is expected when services are rendered. 50% down, with the balance due upon delivery of your eyewear or contact lenses. Please check your preferred method of payment:

- Cash
- Check
- Visa
- MasterCard
- Discover

In accordance with HIPPA (Federal Law regarding confidentiality of your medical information), a doctor's office is not allowed to leave a message on a telephone recorder or with another individual regarding your specific care, or appointments, without your permission.

I give permission for Auburn Eye Care Associates to leave information regarding their office, appointment times, planned procedures, and care instructions on my answering machine or voice mail number they have on record in their offices. I also authorize Auburn Eye Care Associates to leave messages or discuss my care with the following person:

signature _____ **date** _____

Person authorized to receive information described above _____