

# Welcome to Garner Family Eye Care, OD, PA

Please complete the following for our records:

DATE: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Middle Preferred Name

\_\_\_\_\_  
Street Address City State Zip Code Home Phone

Male /  Female SS# \_\_\_\_\_ Birth Date \_\_\_\_\_ Family Physician \_\_\_\_\_

Marital Status (check box)  S  M  D  W E-mail Address \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

\_\_\_\_\_  
Current Employer / School Occupation / Grade Work Phone

\_\_\_\_\_  
Spouse's Name Employer / School Work Phone

\_\_\_\_\_  
Emergency Contact Phone#

Who referred you to / why did you choose our practice? \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

## For Minors / Other Dependents

\_\_\_\_\_  
Father's Name Employer Work Phone Name of Person Responsible for Payment

\_\_\_\_\_  
Mother's Name Employer Work Phone

Parents Marital Status (check box)  S  M  D  W \*Address if different

Family Members That Have Been Patients Here: Relation to Patient

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Insurance Information

Do you have any vision or medical insurance? If so, please list it below:

CHECK BOX:

\_\_\_\_\_  
Vision Insurance Policy Number Group # Card Holder's Name  Y  N Met Deductible?

\_\_\_\_\_  
Primary / Medical Insurance Policy Number Group # Card Holder's Name  Y  N Met Deductible?

\_\_\_\_\_  
Secondary / Medical Insurance Policy Number Group # Card Holder's Name  Y  N Met Deductible?

**\*IF A REFERRAL IS NEEDED FROM THE PATIENT'S INSURANCE COMPANY DUE TO A MEDICAL DIAGNOSIS, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN THAT REFERRAL FROM THE PRIMARY CARE PHYSICIAN.**

## Life Signature on File (For Patient):

I authorize the release of any medical or any other information necessary to process this claim. I also authorize payment of vision / medical benefits to Garner Family Eye Care for services rendered. I understand that I am financially responsible for any amount not covered under my plan.

\_\_\_\_\_  
Signature Date

## For Parent or Guardian of a Minor:

I give Garner Family Eye Care and its doctor's approval to render any routine and or medical treatment, **including dilation**, for my child unless authorized otherwise at a later date.

\_\_\_\_\_  
Signature Date