PREMIER
FAMILY EYECARE

Welcome to Our Office!

Patient Information	
Name	Patient Birth Date (mm/dd/yyyy)
Address	Social Security Number
City	Zip
Occupation	Employer
Home Phone Cell Phone	Work Phone
Email	Marital Status Single Married Widowed
Name of Primary Care Provider_____ Address _____ _____ Office Phone #_____ Date of last check up_____	Do you drive? Yes No Have Children? _____
Race African American American Indian Asian Native Hawaiian/ Pacific Islander White	Hispanic/Latino

Insurance Information: Please fill in and give receptionist your card to make a copy for our records.	
Primary Insurance Company	
Insurance ID Number	
Subscriber Name	Birth Date
Relationship to Subscriber (Please circle one): Self Spouse Dependent Child	
Subscribers place of work	
Secondary insurance company name and number	

****Please present any insurance cards and forms to the receptionist.**

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company and not Premier Family Eyecare. If your insurance company has not reimbursed our office in full within 60 (or 90) days, you will be held responsible.

I attest that the information provided by me on this form is accurate and true to the best of my knowledge.

Name (Please Print)	Date
Patient Signature	