

BLANCHARD FAMILY EYE CARE, PC

PATIENT INFORMATION

(Please use legal name)

PLEASE PRINT CLEARLY

Name of Patient _____ Birth Date ____/____/____

Age: _____ Sex: Male Female Social Security #: ____/____/____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home Phone #: _____

Employer: _____ Work Phone #: _____

Emergency Contact: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Custodial Parent if Patient is Child: _____ Birth Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Home #: (____) _____ Work Phone #: (____) _____ Ext: _____

Employer: _____

Insurance Information: We will need a copy of the insurance card(s) in order to file a claim.

Primary Insurance Coverage: _____

Insured Name: _____ Sex: M / F Birth Date: ____/____/____ SSN# _____

Secondary Insurance Coverage: _____

Insured Name: _____ Sex: M / F Birth Date: ____/____/____ SSN# _____

Third Insurance Coverage: _____

Insured Name: _____ Sex: M / F Birth Date: ____/____/____ SSN# _____

Family Members:

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Patient/Custodial Parent Signature:

I hereby apply for treatment by Dr. Vincent M. Young, O.D. and/or his assistants. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf and I assign the benefits payable to which I am entitled to this practice. I understand that payment is due at the time of service and that I am financially responsible for all charges, whether or not paid by insurance.

I have been given a copy of the HIPPA Privacy Statement.

Signature: _____ **Date:** ____/____/____