

Welcome to Our Office

2014

We are pleased to welcome you to our practice. Please fill out this form as completely as possible. In compliance with insurance requirements, yearly updates are required. This information will allow us to begin the process that ensures your eye health and vision remain at their best. Thank you for your help.

Miss / Mrs. / Ms. / Mr. / Dr. / Rev.

Name _____
Last First Middle Nickname or Preferred

Your Address _____
Street or P.O. Box City State Zip

Date of Birth: ____/____/____ SS# ____-____-____ Height: ____ Weight: ____

Male Female Single Married Divorced Widowed

Race: American Indian Asian Black or African American Hispanic Native Hawaiian or other Pacific Island White

Ethnicity/Heritage: Hispanic/Latino Not Hispanic/Latino Hawaiian / Other Pacific Island

Cell (____) ____-____ Home (____) ____-____ Work (____) ____-____

e-mail _____ Best way to contact me: email postal service telephone text

Your Employer/ phone number _____ Your Family Doctor _____

Your Preferred Pharmacy _____ Where is it? _____

If married, name of spouse _____ Spouse employed by _____

If student, grade level _____ School _____ Teacher _____

If under 18, parent or guardian's name _____

Relation to minor _____ Phone (____) ____-____ Employer _____

Why did you choose our office for your care? _____

Whom may we thank for referring you? _____

Emergency Contact [not in your home]: _____ Number: (____) ____-____

*** INSURANCE INFORMATION ***

How will you be paying today? Full payment by cash, check, credit card or Care Credit Medical or Vision Care insurance with deductible
Insurance information must be presented at time of visit, and cannot be changed after date of service due to electronic filing.

Policy Holder Name _____ SS# ____-____-____ Date of Birth ____/____/____

Primary Insurance Company _____ ID# _____ Group # _____

Secondary Insurance Company _____ ID# _____ Group# _____

Policy Holder's Relationship to Patient _____

I, the undersigned, certify and assign to Dr. Christopher J. Moshoures, Optometrist, PA (Vision Square Eye Care) all insurance benefits. I understand that I am financially responsible for all charges not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature for any and all collection methods. I authorize the doctors to treat me or the patient I am authorized to give permission for and understand that this authorization can only be rescinded by written notice.

Signature

Date