



WELCOME

We are pleased to welcome you to our practice. Please fill out this form as completely as possible. In compliance with HIPPA and insurance requirements, yearly updates are required. If you have questions we will be glad to help..

PATIENT INFORMATION

Patient: _____ Date: _____
(Last) (First) (M.I.)

Date of Birth: _____ Age: _____ SS#: _____

Gender: M F Single Married Widowed Separated Divorced

Mailing Address: _____
Street City State Zip

Telephone: Home: _____ Work: _____ Cell: _____

Physical Address: _____

E-mail: _____ Spouse's Name: _____ Contact#: _____

Employer: _____ Contact#: _____

* We must have an emergency contact person that does NOT live in your home.

Emergency Contact: Name: _____ Relationship: _____

Home, Cell, or Work Phone: _____

Referred By: _____

INSURANCE INFORMATION

Insurance Coverage Yes No

Insurance Information must be presented at time of visit, and cannot be changed after date of service.

Policy Holder name: _____ SS# _____

Primary Ins. Company: _____ ID#: _____ Group#: _____

Secondary Ins. Company: _____ ID#: _____ Group#: _____

Other Ins.: _____

Date of Birth _____ Relationship to patient: _____

PATIENT RESPONSIBILITY

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. This authorization can only be rescinded by written notice.

_____ Date of Birth: _____

Patient/Responsible Party Signature

*If Minor, Parent or Responsible Party Name: _____

SS# _____ Relationship: _____