Please complete every line of information below. Put NA in the blank if it doesn't apply to you. If you have been here in the last 2 years, then just complete any changes since your last visit.

Insurance denials due to inaccurate information waste money. Please do not place us in the position of having to bill you due to denials because you provided us with wrong information.

PATIENT INFORMATION

MR. MRS. MS. MISS DR. (please circle one) FULL NAME _____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONES: DAYTIME_____ CELL_____ **(we MUST know this if you have one)**

E-MAIL_____ **(we MUST know this if you have one)**

BIRTHDATE_____ AGE_____ SOCIAL SECURITY NUMBER_____

YOURPREFERRED NAME_____ EMPLOYER_____

ARE YOU A STUDENT? IF SO, GRADE / YEAR_____ NAME OF SCHOOL/COLLEGE_____

INSURANCE INFORMATION

Please list the following information about your **PRIMARY AND SECONDARY MEDICAL** insurance plans. Please be sure to not mix-up your PRIMARY and SECONDARY plans. Also, please do not confuse your medical and optical/vision plans. You MUST complete this information, even if you gave the receptionist insurance cards to copy.

- **PRIMARY MEDICAL** insurance information [this is MEDICAL, not VISION insurance]

  INSURANCE COMPANY NAME_____INSURANCE NUMBER_____

  Please complete the following information about the policy owner. If the patient is the owner, just write SELF. If the patient's spouse, parent, or guardian is the owner, complete ALL the following information on that person:

  FULL NAME _____ BIRTHDATE_____ SOC SEC #_____

  ADDRESS_____ CITY_____ ST_____ ZIP_____

  EMPLOYER_____ ADDRESS_____ PHONE_____

- **SECONDARY MEDICAL** insurance information [MEDICAL, not VISION insurance]

  INSURANCE COMPANY NAME_____INSURANCE NUMBER_____

  Please complete the following information about the policy owner. If the patient is the owner, just write SELF. If the patient's spouse, parent, or guardian is the owner, complete ALL the following information on that person:

  FULL NAME _____ BIRTHDATE_____ SOC SEC #_____

  ADDRESS_____ CITY_____ ST_____ ZIP_____

  EMPLOYER_____ ADDRESS_____ PHONE_____

- **VISION PLAN** (we must know the EXACT name of your plan)_____