WELCOME TO ADVANTAGE EYE CARE

ACCOUNT NUMBER

Patient Name: **(Last, First, Middle Initial)**	Date Of Birth: / /	Age:	☐ Male ☐ Female	Phone Number: ☐ Home ☐ Cell
Street Address, APT # , City, State, Zip:				Patient's Social Security #: _____ - _____ - _____
Employer Name:				Occupation:
Work Address:				Work Phone Number:
Parent\Guardian Name (if under 18)	Date Of Birth: / /	Email Address:		

Please tell us which of the following influenced you to choose Advantage Eye Care?

☐Yellow Pages ☐Friend/Relative ☐Newspaper ☐School ☐Internet ☐Insurance ☐Other:_____

Please list the media source or name of friend / relative that referred you to us._____

Insurance Information:

Patient Relationship To Insured: ☐**Self** ☐**Spouse** ☐**Child** ☐**Other** _____

Name Of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number: ( ) _____ - _____

Insured's Name: _____ _____ _____
Last **First** **Middle Initial**

Insured's Full Address: _____

_____ _____ _____
City State Zip

Insured's Phone Number: ( ) _____ - _____

Insured's Date of Birth: _____/_____/_____ **Insured's Social Security #:**_____ - _____ - _____

Insured's Policy Number: (May be the same as Insured's SS #) _____

Insured's Employer:_____

Insured's Policy Group Number, If Present: _____

I verify the above information is correct. I authorize the release of any medical or other information necessary to process this claim. I also authorize release of payment to Advantage Eye Care, PC for any services rendered.

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

I HAVE REVIEWED THE INFORMATION ABOVE AND VERRIFY THAT IT IS TRUE AND CORRECT
(For every new visit, make any changes needed & sign initials and date on one of the following spaces provided)

_____ _____ _____ _____ _____ _____