Section A - All Patients Please Complete

Last Name _____First Name _____Middle Initial _____
Street Address _____Apt _____City _____Zip _____
Home Phone: (_____) _____ Work Phone: (_____) _____
Cell Phone: (_____) _____ Email: _____@_____
Date of Birth _____/_____/_____Social Security Number _____ Male____ Female____
Occupation: _____Who referred you to our office? _____
Your Primary Care Physician: _____
List contact name/phone number of person(s) that you authorize to discuss your medical care: _____
_____

I have reviewed and consent to Huntington Eye Care's HIPAA Privacy Policy:

X_____ X_____
Signature Date

Section B – Insurance Information
Not Required If You Are Fully Paying Cash For Today's Visit

Primary Insurance Company: _____
Policy Holder _____Relationship To Patient _____
I.D. #_____ Group Number _____
Date of Birth of Insured _____/_____/_____

Secondary Insurance Company: _____
Policy Holder _____Relationship To Patient _____
I.D. #_____Group Number _____
Date of Birth of Insured _____/_____/_____

I authorize payment to Huntington Eye Care and the release of any information necessary to process my payment:
X_____ X_____
Signature Date

If the health insurance company listed above denies payment to Huntington Eye Care because I am no longer insured with them, I agree to pay for all medical services provided. I will be responsible for all co-pays, co-insurances, and deductibles as determined by my insurance company:
X_____ X_____
Signature Date

USE FOR FUTURE VISITS

*I have updated the information on these forms _____ _____
Signature Date
*I have updated the information on these forms _____ _____
Signature Date
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Signature Date
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Signature Date