NEW ALBANY VISION CLINIC
PATIENT INFORMATION

Patient Name: _____ Circle One: Mr. Mrs. Ms Miss

Prefer to be called: _____ Circle One: Male Female

Circle One: Married Divorced Widowed Single

Physical Address _____ P. O. Box (if applicable) _____

City _____ State _____ Zip _____ — _____

Date of Birth: _____ Age: _____ SSN#: _____

Employer: _____ Occupation: _____

Home Phone: _____ Work: _____ Ext. _____

Cell: _____ Text: Yes No Email: _____

Other #: _____ Relationship to Patient: _____

INSURANCE INFORMATION: <u>WE WILL NEED A COPY OF CARD(S)</u>

Medicaid#: _____ Medicare #: _____

Primary: _____ ID# _____

Insured's Name: _____ DOB: _____ SSN#: _____

Secondary or Supplement: _____ ID# _____

Insured's Name: _____ DOB: _____ SSN#: _____

METHOD OF PAYMENT: CASH CHECK CREDIT/DEBIT CARD

<u>PAYMENT EXPECTED AT TIME SERVICES ARE RENDERED</u>

_____ _____ _____

Signature of Patient or Responsible Party | Date | Relationship to Patient

Responsible Party DOB: _____ SSN# _____

Billing Address (if different from patient) _____