New Patient Information Form

Patient's Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____Work/Cell Phone: _____

Email address: _____

Marital Status (circle one): Married Single Divorced Legally Separated Widowed

Employer: _____ Occupation: _____

Who can we thank for referring you? _____

Insurance Policy Holder Information

Policy Holder's Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Social Security #:_____

Policy Holder's Employer: _____

INSURANCE INFORMATION

_____	_____
Name of Vision Insurance	Name of Medical Insurance
_____	_____
Policy / Identification #	Policy / Identification #
_____	_____
Group #	Group #

We ask all patients to show their insurance cards, so that we may scan them into our system.

FINANCIAL DISCLAIMER

I authorize the release of any medical information necessary to provide the most beneficial and complete eye health examination. I acknowledge that Wyntre Brooke Eye Associates, Inc. will attempt to verify plan eligibility for services and/or materials prior to the exam. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. I understand it is my responsibility to check with the plan administrator if I have any questions regarding my eligibility. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand the Exam Co-Payment is due at the time services are rendered. When materials are ordered (glasses or contact) a 50% deposit must be paid with the remaining balance due when materials are received. I understand that if there is an unpaid balance beyond 30 days, interest will accrue. My account may be turned over to collections and I am responsible for all collections fees that will be added.

_____ _____

Signature Date