Welcome Back to EyeCare Focus

Legal Name _____ **Preferred Name**_____

Parent's Name_____ **Account Responsibility**_____
For patients under the age of 18 years

Social Security#_____ PCP_____Pharmacy_____

Patient Demographics

Gender: □ Female □ Male

Height:_____(Ft/In) **Weight**:_____(lbs)

□ **Non Tobacco user** □ **Tobacco User** What Form?_____ Frequency?_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other □ Unknown

Ethnicity: □ Hispanic or Latino □ Non Hispanic or Latino

Preferred Language:_____

May we confirm your appointments, and notify you when your glasses and contacts come in by email and/or text message? Please indicate your consent by adding your email address and/or cell phone number.

Email address (please print clearly) _____

Cell phone number _____

Would you like information on:

□Lasik Surgery
□Paragon CRT (Corneal Refractive Therapy)
□Contacts
□Bifocal Contacts
□Progressive Lenses
□Prescription Sunglasses
□Vision Therapy
□Other_____

Others who may access my account information: _____

Please read and sign below.

<u>Payment is expected at the time services are rendered, including all items not covered by your insurance.</u>
Most Insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information quoted to us by insurance companies and cannot guarantee your insurance company will pay your claim.

I understand that financial responsibility for my account is mine, and not my insurance company's.
I authorize payment of medical benefits to EyeCare Focus for services.

Signed:_____ **Date**_____