Welcome To EyeCare Focus

Legal Name _____ **Preferred Name**_____

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

Employer_____**Physician**_____**Pharmacy/Location**_____

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 _____

Please take a moment to tell us about Preferred Hobbies, Sports, Other Activities:

Racquet Sports	Swimming/Scuba	Jogging	Baseball	Photography
Hunting/Shooting Golf	Bowling	Fishing/Boating/Sailing	Aviation	Music/Reading
Cycling	Basketball	Automotive	Woodworking	Painting
Traveling	Gardening	Knitting/Metal craft	Computer	Other_____

Would you like information on:

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

How did you hear about our office?

□Referred by_____
□Family_____
□ Other _____
□Yellow Pages
□Insurance Booklet
□Website or Facebook

Others who may access my account information: _____

Please read and sign below.

Payment is expected at the time services are rendered, including all items not covered by your insurance. 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**_____