## Welcome to Our Office

(Please print your information)

Today's Date: _____

| Patient Information | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Patient's Name** | First | | Last | | MI | | | | |
| Address | | | | | | | | | |
| City | | | | State | | Zip | | | |
| Home Phone | ( ) - | | Work Phone | ( ) - | | Cell Phone | ( ) - | | |
| Social Security Number | | | Date of Birth | | | | | | |
| Place of Employment | | | Occupation | | | | | | |
| Name of Spouse | | | Email Address | | | | | | |
| **Insurance Information** | | | | | | | | | |
| **Name of Policy Holder** | First | | Last | | MI | | | | |
| Date of Birth | | | Social Security Number | | | | | | |
| Daytime Phone | ( ) - | | Relationship to Patient | | | | | | |
| Address | | | | | | | | | |
| City | | | | State | | Zip | | | |
| Emergency Contact Name and Number | | | | | | | | | |
| Primary Care Doctor's Name and Phone Number | | | | | | | | | |

**Please present all Vision **and** Medical Insurance cards to the receptionist upon arrival**

**PLEASE NOTE:**

It is the patient's responsibility to know if they are covered by their insurance plan for **"Routine Vision." Contact lens fittings are NOT always covered by insurance.** Please be prepared to pay any additional costs for this service. The patient is responsible for all fees regardless of insurance. **There is a separate copay or charge for contact lens fittings.**

Do you currently wear contact lenses? YES / NO (If yes, what brand?_____)
Have you worn contacts in the past? YES / NO
Are you interested in wearing contact lenses? YES / NO
Are you interested in information on LASIK? YES / NO

Reason for today's visit: _____
How were you referred to our office? _____

I request that payment of authorized Medicare benefits or other insurance be made directly to Carolina Eye Care on Merrimon, O.D., P.A. and its affiliated Doctors for any services rendered to me. I understand medical information about me will be released to my health care financing administration and its agents, as well as any information required to determine the benefits payable for related services.

Patient Signature: _____Date:_____

I give permission to Carolina Eye Care on Merrimon to share my health information with the following people if requested:

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Patient Signature: _____ Date: _____