PATIENT INFORMATION			
NAME (LAST, FIRST, MIDDLE):	SSN #:	DOB:	SEX:
ADDRESS:	HOME PHONE:	CELL PHONE:	
CITY, STATE, ZIP:	EMAIL:		
PRIMARY CARE PHYSICIAN:	ETHNICITY:	RACE:	LANGUAGE:
REFERRING PHYSICIAN:	**How did you hear about our office? ☐ Insurance ☐ Social Media ☐ Doctor ☐ New Eyes Patient (Name):**		

EMPLOYER	
PRIMARY EMPLOYER:	PHONE #:

PHARMACY INFORMATION		
PHARMACY:		
ADDRESS:	CITY, STATE, ZIP:	PHONE #:

RESPONSIBLE PARTY FOR INSURANCE			
CHECK ONE BOX: ☐ SELF o SPOUSE o PARENT (IF SPOUSE OR PARENT FILL IN BOX BELOW)			
NAME (LAST, FIRST, MIDDLE):	SSN #:		DOB:
ADDRESS:	CITY, STATE, ZIP:		RELATIONSHIP:
PHONE NUMBER:	SEX:	CELL PHONE:	

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY:	POLICY #:	
NAME OF INSURED:	GROUP #:	DOB:
ADDRESS:	CITY, STATE, ZIP:	
RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT	COPAY SPECIALIST:	TESTING COPAY:

SECONDARY INSURANCE			
NAME OF INSURANCE COMPANY:	POLICY #:		
NAME OF INSURED:	GROUP #:		DOB:
ADDRESS:	CITY, STATE, ZIP:		
RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ PARENT	PAYS DEDUCT: ☐ YES ☐ NO	PAYS 20%: ☐ YES ☐ NO	REFRACT COVERED: ☐ YES ☐ NO

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY POLICIES

My Signature Below Acknowledges the Receipt of New Eyes Notice of Privacy Policies

Patient Signature	Date Signed	POA/Guarantor/Relationship