



# Confidential Patient Questionnaire

Welcome to Eye 1<sup>st</sup> Vision & Laser. Please take your time to complete the following questions. Please use black ink only and complete the entire form. If you leave a line blank, please initial with "N/A". In accordance with FTC Identity Theft Rule 16 CFR 681:2, please present a Photo ID with current address for photocopying. Additionally, for insurance purposes, we will need to make a copy of your medical and vision insurance card(s).

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Main Phone \_\_\_\_\_ Please Circle: HOME CELL WORK

Alternate Phone \_\_\_\_\_ Please Circle: HOME CELL WORK

E-Mail Address \_\_\_\_\_ Sex: Male Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status: Single Married Divorced

Social Security Number (For Insurance Verification) \_\_\_\_\_

Employed? Yes No Are you a Student? Yes No If, Yes: Full Time Part Time

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

How did you hear about Eye 1<sup>st</sup> Vision & Laser? \_\_\_\_\_

**NOTE: Please remember bring in your current Medical and/or Vision Insurance Cards.**

### AUTHORIZATION

I authorize Eye 1<sup>st</sup> Vision & Laser to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Eye 1<sup>st</sup> Vision & Laser insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I am aware that my insurance is a contract between my insurance company and myself and not Eye 1<sup>st</sup> Vision & Laser. I agree to be responsible for all my insurance co-pays and deductibles for services rendered on my behalf or my dependents.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent or Guardian Signature (If Applicable) \_\_\_\_\_ Date \_\_\_\_\_