Appointment Time_____

PATIENT INFORMATION

PLEASE COMPLETE EACH SECTION BELOW

Have you been seen at Vaught Eye Associates in the past 3 years? YES____ NO____

Patient's Legal Name _____Nick Name_____

SS# _____ Date of Birth _____/_____/_____Age_____ Marital Status:**M S D W**

Home Address _____City_____ State_____ Zip Code_____

Mailing Address _____City_____State_____Zip Code_____

Email _____Employer _____Occupation _____

Home(____)_____Work(____)_____Cell(____)_____ IS IT OK TO TEXT? ☐

Gender: Male____ Female____ **Race/Ethnicity:_____**

Responsible person if patient is a minor or legally dependent.

Name _____ Date of Birth _____SS#_____

Emergency Contact:

Name_____Address_____Phone #_____

Primary Insurance Information

Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other__
Member's Name (if other than yourself) _____
Member's Date of birth____/____/____ Member's SS#_____

Secondary Insurance Information OR Vision Plan

Insurance Company_____Employer Name_____
Relationship to Policyholder: Self_____ Spouse_____ Child_____ Other_____
Member's Name (if other than yourself) _____
Member's Date of birth____/____/____ Member's SS#_____

REASON FOR TODAYS VISIT?

_____

How will payment be made today? VISA MC AMEX DISCOVER CHECK CASH (please circle one)

Payment Authorization: I hereby authorize VAUGHT EYE ASSOCIATES, PA to furnish information concerning my present illness. I direct the insured to pay, without equivocation, directly to the physician, all benefits due to him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all co-payments, co-insurance, deductibles, and any services not covered by my insurance at the time of service. A photocopy of this authorization will be valid as the original.

Consent For Treatment: I am granting consent for me or my legal dependent stated above, to receive medical and/or vision care. I understand that only the care relevant to my present illness may be treated and that the optometrist may recommend further or additional care.

Patient or Guarantor Signature_____Date_____

(For office use only) **JMV ELW GMW DV**

MEDICAL DX REQUIRED*ROUTINE DX REQUIRED**

Recall Date_____ Follow up/PC _____ Referral _____ OVER →