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Welcome To Our Office.

Date: _____

In an effort to provide you with the best possible care, please provide us with the following information:

FULL NAME: _____

Preferred Name: _____ DOB: _____ Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Work: _____

Cell: _____ Email Address: _____

Social Security #: _____ and/or Drivers License: _____ State: _____

Spouse or Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Account Responsibility: _____ Phone: _____

Referred By: _____ Primary Care Physician: _____

InFocus Eye Care is an ophthalmology office and provides medical treatment, if you have a vision benefit and would like us to bill under it, please notify our front office.
Will you be using your vision benefit today? ___ Yes ___ No

May we speak to anyone else in regards to your treatment and account with our office, if so whom: ___ Yes ___ No

Name: _____ Relationship: _____

Insurance Information:
Please fill in even if we have scanned your insurance card(s).

Primary Insurance Company: _____

ID#: _____ Group Number: _____ Insured Name: _____

For Medicare patients only. Please note: If you are not a Medicare patient we ask that you bill your own secondary insurance.

Secondary Insurance Company: _____

ID#: _____ Group Number: _____ Insured Name: _____

Patient Signature Date