ACADEMY VISION SCIENCE CLINIC

PATIENT INFORMATION

PATIENTS NAME: NICKNAME:

GENDER: MALE FEMALE EMPLOYER: OCCUPATION:

SSN: BIRTHDATE: EMAIL:

HOME PHONE: ( ) CELL: ( ) WORK: ( )

ADDRESS:

CITY: STATE: ZIP:

IF MINOR, PARENT'S NAME:

EMERGENCY CONTACT: RELATION:

PHONE: ( )

RESPONSIBLE PARTY/VISION INSURANCE

NAME OF POLICY HOLDER: RELATION:

INSURED'S DATE OF BIRTH: SSN:

ADDRESS, IF DIFFERENT:

INSURED'S EMPLOYER: PHONE NUMBER: ( )

INSURANCE CARRIER: POLICY NUMBER:

GROUP NUMBER: EFFECTIVE DATE:

PRIMARY INSURANCE

NAME OF POLICY HOLDER: RELATION:

INSURED'S DATE OF BIRTH: SSN:

ADDRESS, IF DIFFERENT:

INSURED'S EMPLOYER: PHONE NUMBER: ( )

INSURANCE CARRIER: POLICY NUMBER:

GROUP NUMBER: EFFECTIVE DATE:

SECONDARY INSURANCE

NAME OF POLICY HOLDER: RELATION:

INSURED'S DATE OF BIRTH: SSN:

ADDRESS, IF DIFFERENT:

INSURED'S EMPLOYER: PHONE NUMBER: ( )

INSURANCE CARRIER: POLICY NUMBER:

GROUP NUMBER: EFFECTIVE DATE:

ACKNOWLEDGEMENT

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS TRUE. I HAVE READ AND UNDERSTAND THE "FINANCIAL POLICY AND AGREEMENT" ON THE FOLLOWING PAGE.

SIGNATURE: DATE: