Contact Lens & Vision

INSURANCE INFORMATION

Patient Information

Patient Name (*Please Print Clearly*) **Date of Birth**

____ ___/___/___

Last Name *First Name* *Middle Initial*

Address

____

Street *City* *State* *Zip Code*

Sex
☐ M ☐ F

Relationship to Insured
☐ Self ☐ Spouse ☐ Child
☐ Other

Patient Status
☐ Single ☐ Married ☐ Other
☐ Employed ☐ Full-Time Student ☐ Part-Time Student

Is Patient Condition Related To
Employment? (Current or Previous)
☐ Yes ☐ No
Auto Accident?
☐ Yes ☐ No
Other Accident?
☐ Yes ☐ No

Insurance Information **Primary**

____

Insurance Name *Insurance ID Number* *Insurance Group Number*

Insured's Name **Insured's Date of Birth**

____ ___/___/___

Last Name *First Name* *Middle Initial*

Insured's SS#

____

Insured's Address

____

Street *City* *State* *Zip Code*

Sex
☐ M ☐ F

Employers Name or School Name ____

Additional Insurance Information **Secondary**

____

Insurance Name *Insurance ID Number* *Insurance Group Number*

Insured's Name **Insured's Date of Birth**

____ ___/___/___

Last Name *First Name* *Middle Initial*

Insured's SS#

____

Insured's Address

____

Street *City* *State* *Zip Code*

Sex
☐ M ☐ F

Patient Signature ____ **Date** ____________________