Complete Family EyeCare, LLC
Welcome Form

Please fill out our welcome form as accurately as you can. All information is kept confidential.

Name: ____________________________ Date of Birth: _____________
Street Address: ____
City: ______________________ State: ________ Zip Code: ___________
Phone #: (H) _____________ (C) ______________ (W) _____________
Email: ____
Occupation: ____
How did you hear of us? _______________________________________

Insurance Information

Please list both vision and medical coverage (if applicable) as well as primary and secondary insurances.

Insurance Name: ____
Name of Insured: ______________________ Date of Birth: ___________
Employer: ___________________ Relationship to insured: ___________
ID #: _______________________ Group #: ________________________

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Employer: ___________________ Relationship to insured: ___________
ID #: _______________________ Group #: ________________________

Please note insurance regulations mandate that we charge for all office visits that require you to see the physician. They also mandate that co-pays/payments are paid at the time of service. All patients must be aware of their insurance benefits and coverage at the time of their scheduled appointment and inform us accordingly. You are responsible for all charges not covered by your insurance. All insurance cards must be given for exams, glasses, or contacts. We cannot back date authorizations for exams, eyeglasses or contacts. Once you've purchased glasses/contacts we cannot submit to your insurance unless we were made aware of your insurance prior to placing the order. You can, of course, submit your receipt to your insurance company for reimbursement.

Signed: ________________________________ Date: ____________________
Parent/Guardian if patient is a minor.