RIVER CITY EYECARE

Personal Information

Date ________ / ________ / ________ Nickname ___________________________________

Title _____ First Name _____________________________ MI________ Last Name ___________________________________

Street Address _____________________________________ City ___________________ State ______ Zip _______________

Home Phone (______) ______-_______ Cell (______) ______-_______ Work (______) ______-_______

Birth Date ____ / ____ / ________ Male or Female SSN# ______-_______-_________

Email address _______________________________ Preferred contact Method: Home Phone / Cell Phone / Email

Marital Status _________________ Employer _____________________________ Occupation ________________________

Emergency Contact _____________________________ Phone (______) ______-_______ Relationship ________________

Primary Care Physician __________________________

Name of Guarantor (Person Responsible for the Account)_______________________ Phone (______) ______-_______

Patients' relationship to Guarantor (Circle One) Self Spouse Child Other

How did you hear about our office? (Circle one) Insurance Yelp Google Facebook Drive/walk by

I was referred by my family / friend. Name: ________________________ Other: ____________________________

Lifestyle Questions

Are you satisfied with your distance and near vision? Yes or No Do you wear Sunglasses? Yes or No

Do you wear Contact Lenses? Yes or No If yes, which brand _________________________

Are you interested in Contact Lenses? Yes or No

Are you interested in LASIK surgery? Yes or No

Do you work on the computer? Yes or No If yes, how many hours per day? _____________

What are your hobbies? ____

Do you play any sports? Yes or No If yes, which sport? ____

Financial Agreement

Insurance Verification is not a guarantee of payment. We will verify and bill your insurance as a courtesy. All fees for service not covered and or paid by insurance including co-payments and deductibles will be the responsibility of the patient's guarantor at the time services are rendered. We accept the following as payment cash, check, money orders, Visa, Mastercard, & American Express. I hereby authorize River City Eyecare to exchange information regarding my care and benefits with the above listed insurance company or companies for the purpose of collecting professional fees on my behalf. I assign all benefits payable to River City Eyecare. To the best of my knowledge this information is accurate as of the date. I accept full responsibility for all charges related to my treatment that are not covered by my insurance.

Signature of patient or guarantor ____**Date**___________________