CARY EYE CENTER, PLLC.

PERSONAL INFORMATION - PLEASE PRINT			CHART #		
PATIENT NAME (FIRST, MIDDLE INITIAL, LAST)			BIRTH DATE	AGE	SEX M F / MARITAL STATUS M W D S
PATIENT ADDRESS					
ZIP CODE	CITY	STATE	EMAIL ADDRESS		
PREFERRED LANGUAGE		SOCIAL SECURITY #			
DRIVER'S LICENSE #			STATE		
HOME PHONE	WORK PHONE		CELL PHONE		
PREFERRED METHOD OF CONTACT	□EMAIL □TEXT □ PHONE				
CURRENT EMPLOYER/SCHOOL		OCCUPATION/GRADE			
Emergency Contact		Phone#	Relationship to patient		
REFERRING PHYSICIAN					

RACE □American Indian or Alaska Native □Asian □Black or African American □White □Other □Friend
□Native Hawaiian or Other Pacific Islander

ETHNICITY □Hispanic or Latino □Not Hispanic or Latino

WHOM MAY WE THANK FOR REFERRING YOU?

How did you hear about our practice? □Web Search/Internet □CEC Website □School □Insurance Company □Yellow Pages

INSURANCE INFORMATION

VISION INSURANCE	MEMBER NUMBER	GROUP#	CARD HOLDERS NAME	CARD HOLDERS DOB
PRIMARY MEDICAL INS.	MEMBER NUMBER	GROUP#	GROUP NAME	EFFECTIVE DATE
SEC MEDICAL INS	MEMBER NUMBER	GROUP#	GROUP NAME	EFFECTIVE DATE

Authorization to Release Assign Insurance Benefits: I understand that I am financially responsible to Cary Eye Center for charges. In the case of default on payment of this account, I agree to pay all collection costs, attorney fees, and court cost incurred in attempting to collect on the outstanding balance.

Office Financial Policies: Payment is expected at the time of service. This includes all co-pays, deductibles and outstanding balances. For your convenience, we offer the following methods of payments:

CASH CHECK MASTERCARD VISA DISCOVER

*****There is a $35.00 fee for a check returned by the bank for any reason*****

Missed Appointment Policy: If you must cancel your appointment, please do so at least one (1) business day in advance or you may be charged a **$50.00 No Show Fee.**

Your signature below signifies your understanding, acceptance and agreement to our office policies.

Responsible Party Signature _____ Date _____