WELCOME TO CLOSTER EYE CARE

TODAY'S DATE: / /

PATIENT INFORMATION	
NAME: (LAST) (FIRST)	BIRTH DATE: / / SEX: M F
ADDRESS:	
CITY: STATE: ZIP:	
OCCUPATION: EMPLOYER:	
HOME PHONE: CELL PHONE:	
E-MAIL: @	

INSURANCE INFORMATION	
INSURANCE COMPANY:	SS#
SUBSCRIBER NAME: (LAST) (FIRST)	BIRTH DATE: / / SEX: M F
RELATIONSHIP TO SUBSCRIBER (PLEASE CIRCLE ONE) SELF SPOUSE CHILD	
NAME OF VISION PLAN	ID#

**** PLEASE PRESENT ANY INSURANCE CARDS AND FORMS TO THE RECEPTIONIST.**

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION TO PROCESS MY INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY DOCTOR. IT IS MY UNDERSTANDING THAT I AM RESPONSIBLE TO OBTAIN ANY AND ALL REFERRALS THAT MY INSURANCE COMPANY REQUIRES FOR SERVICE PERFORMED BY THAT DOCTOR. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE.

PATIENT NAME (PLEASE PRINT)	DATE: / /
PATIENT SIGNATURE	