PATIENT INFORMATION

Patients Legal Name: _____

Preferred Name: _____

Name of Spouse or Legal Guardian: _____

Date of Birth: _____/_____/_____ Social Security # _____-_____-_____

Street Address: _____

City: _____State: _____Zip: _____

Contact Information:
Home: (____) _____-_____

Work: (____) _____-_____

Cell/Mobile: (____) _____-_____

EMAIL Address: _____

Occupation: _____

Employer Name: _____

Employer Address:
Street Address: _____

City: _____State: _____Zip: _____

INSURANCE INFORMATION:

Name of Medical Insurance: _____

Member ID: _____ Policy Holder's Name: _____

Customer Svc. Phone: (_____) _____-_____

Name of Vision Insurance: _____

Member ID: _____ Policy Holder's Name: _____

Customer Svc. Phone: (_____) _____-_____

Referral Information – How did you learn about our office? Please check all that apply.

☐ Relative ☐ Friend ☐ Internet ☐ Doctor Referral ☐ Insurance ☐ Location ☐ Other

If you were referred by a current patient, whom may we thank? _____

I hereby authorize any necessary treatment by the optometrists in the practice of Dr. Snively and agree to be responsible for my bill and any collection fees made necessary to collect payment of services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize the office of Dr. Snively to release or obtain information from my attending physician or any medical facility.

Patient's Signature/Legal Guardian _____ Date_____

Interest charge 1.5% per month or 18% per annum. Attorney's fees added if necessary for collection.