LINDY EYE CARE entry form:

Name: (Last, first)_____**DOB**____/____/_____ **Gender:** M or F

Phone: (Home)_____(Cell)_____ **Preferred**: H C

Email address:_____ **Soc Sec #**:_____

Home address:_____

New patients: How did you find out about our office?_____ _____

If referred, who may we thank for the referral?_____

Insurance Information: (note: Medical insurance covers medical, but not refraction or contact lens fees)

PLEASE LEAVE YOUR INSURANCE CARDS OUT FOR RECEPTIONIST. THANK YOU

PRIMARY Medical Insurance:_____ID#:_____

Policy holder name:_____Policy holder DOB / / Relationship to card holder_____

SECONDARY Medical Ins:_____ID#:_____

Policy holder name:_____Policy holder DOB / / Relationship to card holder_____

OPTICAL Insurance:_____Policy holder _____Policy holder DOB / /

Policy holder ID or SS#_____Relationship to policy holder_____

Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits from insurance to the provider. I understand that I am responsible for any balance my insurance does not pay.

Thank you for letting us serve you!

Please sign and date below:

_____

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