Eyecare Associates
OF COLUMBUS

Date _____

WELCOME TO OUR OFFICE PATIENT INFORMATION

NAME AND ADDRESS

☐ Single ☐ Married

Patient Name _____ Nickname _____ Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ Email Address _____

Preferred Phone
☐ Home
☐ Cell
☐ Work

Patient's Employer _____ Employer Address _____

Spouse Name _____ Spouse Employer _____

Responsible for Account: **(Required)** _____

(If patient is a minor) **(Required)**
Parent/Guardian Name _____ Social Security # _____

Parent/Guardian Employer **(Required)** _____

Parent/Guardian Name _____ Social Security # _____

Parent/Guardian Employer **(Required)** _____

ALL Copays and noncovered services are due at time of appointment. In addition, 1/2 down payment is required on any materials ordered (glasses and contacts).

VISION INSURANCE

Vision Insurance _____

Subscribers Name _____

Subscribers Birth Date _____

Subscribers Employer _____

MEDICAL INSURANCE

Primary Medical Insurance _____

Subscribers Name _____

Subscribers SSN _____

Subscribers Birth Date _____

Subscribers Employer _____

Secondary Medical Insurance _____

Subscribers Name _____

Subscribers SSN _____

Subscribers Birth Date _____