

(circle one) Mr. Mrs. Ms. Miss Master Dr. Prof. Rev. Sister

NAME: _____ SEX: _____ SUFFIX: _____

DOB: _____ AGE: _____ BIRTH STATE: _____

SSN: _____ (Patient's Social Security number)

MOTHER'S MAIDEN NAME: _____

PRIMARY LANGUAGE: _____

RACE: (circle one) American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Other Race

ETHNICITY: (circle one) Unknown, not Hispanic or Latino, Hispanic or Latino

ADDRESS:

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

COMMUNICATION:

PREFERENCE: _____ (call home, work, cell, email, etc)

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____ CARRIER: _____ (AT&T, Verizon, etc.)

E-MAIL: _____

Who is your primary care doctor? _____ Town _____

Your insurance company may not pay for all your **COVERED** services. A "covered service" may require that you pay your deductible and/or co-pay and co-insurance. In the event that your insurance company **denies** your claim, you agree to pay for services rendered. Your signature below authorizes us to bill your insurance company on your behalf. It also serves to authorize any information your insurance company may require to process your claim.

INFORMATION:

INSURANCE PLAN: _____ VISION PLAN: _____

POLICYHOLDER: _____ DATE OF BIRTH: _____

POLICYHOLDER PLACE OF EMPLOYMENT: _____

Signature

Date

RESPONSIBLE FOR PAYMENT: _____ (if patient is a minor)

Social Security Number: _____

I am familiar with the Eye Care & Eye Wear Center of Maine Notice of Privacy Practice

Signature

Date