EYECONiC eyecare
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eyeconiceyecare.com

PATIENT INFORMATION

Name (Last, First, Middle Intial)	Date of Birth	Social Security #	Sex
Address	Home Phone	Cell Phone	Work Phone

City, State, Zip	Primary Employer
E-Mail Address	Employer Address
Primary Care Physcian	Employer City, State, Zip
Referred By	Secondary Billing Address (if Applicable)
Contact Lenses: ☐Yes ☐No	City, State, Zip

RESPONSIBLE PARTY INFORMATION

Name (Last, First, Middle Intial)	Social Security #	Date of Birth	Sex

Address	Emergency Contact
City, State, Zip	Address
Home Phone	City, State, Zip
Relationship To Patient	Home Phone

PRIMARY INSURANCE

Name of Insurance Company	Policy# / ID #	
Name of Insured	Group #	
Address of Insurance Company	Co-Pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

SECONDARY INSURANCE

Name of Insurance Company	Policy# / ID #	
Name of Insured	Group #	
Address of Insurance Company	Co-Pay Amount	
City, State, Zip	Insured Social Security #	Insured Date of Birth
Relationship to Patient	Effective Date	Expiration Date

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practioners. I authorize my insurance benefits be paid directly to the physcian. I understand that I am responsible for all co-pays, deductibles and co-insurance amounts.

Signature of Patient / Guardian

Date