Patient Information

LAKES FAMILY EYECARE

Date: _____

Name: _____ _____ _____
First MI Last

Date of Birth: _____/_____/_____ Gender: M_____ F_____

*If patient is a minor, name(s) of parent(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (c): _(____)_____ Phone (h): _(____)_____ Phone (w):_(____)_____

Employer/Occupation: _____

How did you find us? _____

Email: _____

Insurance: _____

We will submit charges to your insurance for you. However, charges that are not covered will be due at the time of service. Payment will be made via: Cash _____ Check _____ Credit Card _____ HSA _____

If the wrong insurance information is given, the patient will be responsible for charges incurred.

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION:

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Signature of Patient/Guardian: _____