STRATFORD EYE CARE OPTOMETRY

Title: ☐Ms. ☐Mrs. ☐Mr. ☐Dr. ☐Minor Today's Date: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____ City/Zip: _____

Social Security #: _____ Preferred Phone: ☐ Home ☐ Cell ☐ Work

Occupation: _____ Home : _____

Employer: _____ Cell: _____

Marital Status: ☐Single ☐Married ☐ Other _____ Work: _____

Referred By: _____ Email: _____

Emergency Contact: _____ Emergency Phone: _____

Race: ☐Hispanic/Latino ☐American Indian or Alaska Native ☐Caucasian

☐Asian ☐Black/African American ☐ Other _____

VISION INSURANCE INFORMATION

Name of Vision Insurance: ☐ VSP ☐ Eyemed ☐ MES ☐ Medicare ☐ Other_____

Policy Holder Name: _____ Policy Holder DOB: _____

MEDICAL INSURANCE INFORMATION

Name of Medical Insurance: _____ Member ID#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I acknowledge that I have received Stratford Eye Care Optometry Notice of Private Practices (you may request a copy for your records).

Signature: _____ Date: _____

ASSIGNMENT OF BENEIFTS AND FINANCIAL RESPONSIBILITY

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to be made directly to Bhakta Optometric, PC (DBA : Stratford Eye Care Optometry), unless payment is made in full at time of service. I agree to bear full responsibility for co-pays, deductibles, non-covered and denied services by my insurance.

Signature: _____ Date: _____

Relationship to Patient (If minor): _____