CAROLINA EYE CARE
DENVER - LINCOLNTON

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Nickname
Address			
City, State, Zip			
Primary Phone Number		Cell Phone Number Ok to Txt Y/N	Employed or Student? ☐ ☐
Date of Birth	Sex M/F	Marital Status S/M/D/W	Social Securtiy Number / Full or Part Time? ☐ ☐
Email Address		Employer	Employer Phone Number
Emergency Contact		Relationship	Phone Number
Race	Ethnicity ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other		Preferred Language ☐ English ☐ Spanish ☐ Other

PLEASE FILL OUT IN ITS ENTIRETY — **INSURED POLICY HOLDER INFORMATION** — **PLEASE FILL OUT IN ITS ENTIRETY**

As a courtesy to our patients, we will file your insurance claim for you. In order to do so correctly, and timely, we ask that you please provide us with all of your insurance information. Failure to complete the insurance portion could result in denials of your visit through your insurance and would result in you incurring the self pay rate of your visit. By signing this form, you are responsible for any unpaid balances that are denied by your insurance carrier.

Name	Phone Number
Address	Social Security Number
City, State, Zip	Relationship to Patient

VISION INSURANCE

Name of Carrier	Subscriber ID#	Group #	
Subscriber Name	Relationship to Patient	Date of Birth	Social Security #

MEDICAL INSURANCE

Name of Carrier	Subscriber ID#	Group #	
Subscriber Name	Relationship to Patient	Date of Birth	Social Security #

How did you hear about us? **Referred by:**

I certify that that the information given by me as documented above is correct. I also certify that upon my request, I have been given these forms for review. Carolina Eye Care Financial Poilcy and Notice Of Privacy Practice.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy and Notice of Privacy Practices.

Signature_____ **Relationship to Patient** _____ **Date** _____