WELCOME TO  **SEE LIFE**

family VISION SOURCE™

Last Name: **First Name:** **MI:**

Nick Name: **Date of Birth:**

Address:

City, State Zip:

Phone: **Cell #:** Texting OK? [ ]Y [ ]N

Email: _____@_____

Patient Employer (or School) :

Patient Occupation (or Grade if in School):

What is the best way to reach you?: Email / Telephone / Text *(Circle One)*

Race	Ethnicity
[ ] Alaska Native or American Indian [ ] Asian [ ] Black/African American [ ] Hispanic [ ] Native Hawaiian [ ] Pacific Islander [ ] White	[ ] Native - Hawaiian/Pacific Islander [ ] Hispanic or Latino [ ] No Hispanic or Latino **Preferred Language (Check One)** [ ] English [ ] Spanish

Who may we thank for referring you to our office: _____

****IMPORTANT** REQUIRED IF YOU WOULD LIKE YOUR INSURED TO BE BILLED**

We need the information for the person listed as the **Primary** person on the insurance policy. Your insurance company requires this information to process claims on your behalf.

Policy Holder Name: _____

Policy Holder SSN: _____

Policy Holder Date of Birth: _____

Policy Holder Employer: _____

By signing, you agree to our HIPAA policy, accept all copays and fees not covered by your vision or medical plan, and that all provided insurance information is current.

Signature: _____