Name: ____, ____________________________________ ______________
Last First Middle Int.

Address: ____ ________________________
Street Apt/Unit/Floor

_____________________ _________ _____________ **Primary Phone Number:** (_______) ________ - _________ Cell/Home
City State Zip Code

Date of Birth: ________ /________ /____________ **S.S #** (*Needed for Insurance billing*) ___________ - _________ - ____________

Email Address: ____

Sex: M F **Marital Status:** S M D W **Spouse's Name:** ______________________________
(IF APPLICABLE)

If under 18 Mother/Father's Name: ____

Employer/Occupation: ____

Primary Care Physician: ________________________________ **Preferred Pharmacy:** ________________________________

Emergency Contact/POA: ____ ______________________________
Name Relationship

Contact Number: (_______) _______ - _________ **Can discuss your care with this person**: YES / NO

INSURANCE INFORMATION

Vision Insurance : AVESIS BAI EYEMED SUPERIOR VBA VSP OTHER:________________________________

Policy Holder: SELF SPOUSE PARENT

Name (other than SELF): ________________________________ DOB:______ / ______ / _________ Last 4 S.S #: ____________

PRIMARY Medical Insurance: AETNA CIGNA HIGHMARK HUMANA MEDICARE TRICARE UHC UPMC OTHER:________________________

Policy Holder Name (other than SELF): ____

Relation: SELF SPOUSE PARENT DOB:_____ / _______ / ___________ S.S # _________ - _______ - ____________

*****IF YOU HAVE A SECONDARY INSURANCE AND WOULD LIKE IT BILLED AFTER THE PRIMARY, PLEASE ENSURE THAT THE** PROPER INFORMATION IS FILLED OUT COMPLETELY***

SECONDARY Medical Insurance: AETNA CIGNA HIGHMARK HUMANA MEDICARE TRICARE UHC UPMC OTHER:_________________________

Policy Holder Name (other than SELF) ____

Relation: SELF SPOUSE PARENT DOB:_____ / _______ / ___________ S.S # _________ - _______ - ____________

PATIENT'S INSURANCE AUTHORIZATION/SIGNATURE ON FILE:

I request that payment of authorized insurance benefits be made to either me or on my behalf to Bayfront Eyecare for any services furnished for me/my dependent by the physician/supplier. I authorize any holder of hospital or medical information about me/my dependent to be released to the above named insurance company(s) and its agents, any information needed to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that, regardless of my insurance status, I am ultimately responsible for payment of me/my dependent's account.

____ ___________________________
Insured's Signature Date