

# Welcome to Legacy Eye Care, LLC.

## Patient Information:

Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_  
Email Address: \_\_\_\_\_

Please **Circle** the appropriate status:    Male    Female    Minor    Single    Married  
Race: African American    Asian American    Caucasian    Hispanic    Native American    Other

Emergency Contact Person's name and relationship to you: \_\_\_\_\_ Phone : (\_\_\_\_\_) \_\_\_\_\_

How did you hear about Legacy Eye Care? \_\_\_\_\_

Primary Care Provider's name (Family Doctor): \_\_\_\_\_

If you do NOT wish to receive messages regarding appointments, please check here.

## Person Responsible for Bill (If different from patient):

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Please check here if you are paying as **Self Pay** (not using insurance):

**Do you have a separate Vision Insurance?                    Y / N**

***(Advantica, Aevisis, AlwaysCare, Block Vision, Davis Vision, MES Vision, NVA, Spectera (previously called Optum Health Vision), Spectra Vision, Superior Vision)***

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Name of Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_  
ID#: \_\_\_\_\_

**Note:** We bill your insurance company as a courtesy to our patients. Most Insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies!!! Please understand that the benefit requirements such as referrals etc. for your insurance plan is also your responsibility. Please contact your representative or your primary care doctor's office to obtain the information needed for your visit with us. Please also understand that financial responsibility for your account is yours, not your insurance company's.

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the physician or supplier for services.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Insurance Information:**

**Primary Medical Insurance Co:** \_\_\_\_\_ **Relationship to Pt:** \_\_\_\_\_  
**Name of Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Name of Employer:** \_\_\_\_\_ **Work Phone: (\_\_\_\_\_)** \_\_\_\_\_  
**ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Secondary Medical Insurance Co:** \_\_\_\_\_  
**Name of Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Name of Employer:** \_\_\_\_\_ **Work Phone: (\_\_\_\_\_)** \_\_\_\_\_  
**ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Please list any medications that you are taking if you do NOT have a list:**