



LINCOLN EYE CARE CENTER

Patient Information Form

First Name _____ Middle Initial _____ Last Name _____ Title: Mr. Mrs. Ms. Dr.

Name you wish to be called _____ Date of Birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Occupation _____ Social Security# _____

Employer _____ Work Phone _____

Spouse _____ If patient is a child, parent/guardian's name _____

Please present your insurance cards at the front desk at the time of your visit.

I acknowledge that I have been given the opportunity to read, and or obtain, a copy of Lincoln Eye Care's privacy notice.

I authorize the release of any medical or other information to process my insurance claims. I also authorize payment of medical benefits to my doctor. It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for services performed by my doctor. I also understand that I am responsible for any charges not covered by my insurance.

Our policy: Payment for professional services is expected when services are rendered. A deposit is required on all orders, and the balance is due to be paid upon delivery of any eyewear or contact lenses.

Signature

Date

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