EYE CARE ASSOCIATES OF HAWAII *Vision Source*

Welcome to Eye Care Associates of Hawaii *Vision Source*. Thank you for choosing us for your optometric care. We are delighted to have you as a patient and appreciate the confidence you placed with us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other:_____ ☐ Male ☐ Female

First Name Middle Initial Last Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone/ Include Area Code Work or Cell Phone

E-mail Address Spouse or Parent(s) Name Person Responsible for Account

Patient Employer _____ Occupation _____

EMERGENCY CONTACT INFORMATION

Name Relationship to Patient Phone

How were you referred to our office?

☐ **Phone Book** ☐ **Advertisement** ☐ **School** ☐ **Insurance Listing** ☐ **Other** _____

Doctor (Name) _____ **Patient (Name)** _____

Insurance Information

Name of PRIMARY Insurance Company

Insured Name Insured Date of Birth Insured ID Number

Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part Time Student

Name of SECONDARY Insurance Company

Insured Name Insured Date of Birth Insured ID Number

Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part Time Student

Please Read and Sign:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Eye Care Associates of Hawaii. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature Date