LONGVIEW EYE ASSOCIATES

Patient Information Form

Last Name | First Name | Middle Initial | Date of Birth | Age

Mailing Address | City | State, Zip | SSN (- -)

E-mail | Home Phone | Cell Phone | **Sex:** Male Female

Send Notifications by: Email Text Message Both **Marital Status:** Single Married Widowed Divorced

Employer | Employer Phone | Occupation

Person Responsible for Charges | Relationship to patient | Home Phone | Work Phone

Emergency Contact Name | Relationship to patient | Home Phone | Work Phone

Vision Insurance Information:

Policy Holder's Name

Insurance Company | Self Spouse Child Other — Relationship to the Insured

Policy Holder's ID Number | Policy Group Number | Policy Holder's Date of Birth (/ /)

Policy Holder's Phone Number | Policy Holder's Address | Policy Holder's Sex (M or F)

Medical Insurance Information

Policy Holder's Name

Insurance Company | Self Spouse Child Other — Relationship to the Insured

Policy Holder's ID Number | Policy Group Number | Policy Holder's Date of Birth (/ /)

Policy Holder's Phone Number | Policy Holder's Address | Policy Holder's Sex (M or F)

Self-Pay Statement

I understand that by notifying Longview Eye Associates that I do not have insurance, I will be paying privately. In doing this I am releasing Longview Eye Associates of any refund obligations if I choose to file Insurance on my own.

Patient Name | Patient Signature | Date