Hayes Eye Center
Patient Information

Name: ☐Dr. ☐Mr. ☐Mrs. ☐Ms. _____

Today's Date: _____ **Date of Birth:** _____ **Gender:** ☐Male ☐ Female

Home Address: _____

City: _____ **State:**_____ **Zip**_____

Phone: (H)_____ **(W)**_____ **(C)**_____

Call me at: ☐Home ☐Work ☐Cell **Preferred time of day to call:** ☐Morning ☐Evening

Social Security Number: _____ - ____ - _____

Occupation: _____ **Employer/School:** _____

Guardian (if under 18): _____ **Relationship:** _____

Address (If different): _____

City: _____ **State:**_____ **Zip**_____

In case of an emergency, please contact:

Emergency contact name: _____ **Relationship:** _____

Emergency contact phone number: _____

Insurance Information

Please present all insurance cards and forms to receptionist to copy and verify.

Vision Insurance: _____

Primary Medical Insurance: _____

Secondary Medical Insurance: _____

Person Insured: _____ **Date of Birth:** _____

Relationship to Patient: _____

Who is financially responsible for this visit? _____

Name **Relationship to patient**

I understand that payment for health care services is due the day services are rendered. I further understand that, if insurance applies to the services, I am responsible for all co-pays and/or deductibles and any services or materials not covered by insurance, and I am responsible for presenting my insurance information the day of my visit. I agree to pay all charges that I am responsible for today. Should my account become delinquent, I understand that I am responsible for all collection fees.

_____ _____

Signature of Responsible Party (18 years or older) **Date**