Welcome To Broadway Eyecare Center

PERSONAL INFORMATION

LAST _____ FIRST _____ MI___ NICKNAME _____

HOME _____ CELL _____ WORK _____

PREFERRED FORM OF COMMUNICATION email text cell home work

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DOB _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

Preferred language _____ Race _____ Ethnicity _____

EMAIL _____ REFERRED BY _____

*If you would like to have access to your medical records, receive special offers and product information via email. You may unsubscribe from email communication you receive from our practice at any time. The mailing list is private and will not be sold.

INSURANCE INFORMATION

VISION INSURANCE

INSURANCE _____ SUBSCRIBER SS# _____

ID # _____ GROUP # _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB _____

SUBSCRIBER'S EMPLOYER _____

MEDICAL INSURANCE

INSURANCE _____ SUBSCRIBER SS# _____

ID # _____ GROUP # _____

SUBSCRIBER'S NAME _____ SUBSCRIBER'S DOB _____

SUBSCRIBER'S EMPLOYER _____

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to **Broadway Eyecare Center.** I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that I am responsible for charges not paid by insurance plan.

SIGNATURE _____ DATE _____