

WELCOME TO MID-PLAINS EYECARE CENTER

Date _____, 20____

Last Name _____ First _____ Middle _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Work _____ Cell _____

Date of Birth ____/____/____ Age _____ M F Single/ Married/Divorced/Widowed

Patient's SSN# _____ - _____ - _____ Email address _____

Employer or School _____ Occupation or Grade _____

Spouse or Parent's Name _____ Spouse's Date of Birth ____/____/____

Spouse or Parent's Work _____ Spouse or Parent's work phone _____

Emergency Contact _____ Phone _____

Relationship to Patient _____

For our new patients:

Whom may we thank for referring you to our office? _____

**Insurance Information –
Please present your insurance cards (both medical and vision).**

Most Medical insurances do not cover routine vision care and eyeglasses.

If you have questions about your coverage, please call the number listed on the back of your insurance card and inquire about your routine vision coverage.

Guarantor: _____
(Who will be responsible for payment of the account today?)

Relationship to Patient _____

How will you settle your account today? Cash Check Credit Card

Do you participate in a flex spending account? Yes No

**** PLEASE SIGN PAGE 2 WHERE INDICATED**