Welcome To Baxter Eye Care Patient Number: _____ Age: ___

Mr. ___ Ms. ___ Mrs. ___ Miss ___ Dr. ___

First Name	**Mi**	**Last Name**	**Preferred Name**
_____	___	_____	_____

Date of Birth	**Mailing Address**	**Soc. Sec. #**
_____	_____	_____

***Phone Numbers*:**

Home	**Office**	**Cell**
_____	_____	_____

***Reason for today's visit*:**
Exam Only ___ Exam & Contact Lens Fitting ___ Exam & Glasses ___

How Did You Select Our Office?

***Vision Insurance*:**
Insurance Name and Address _____
ID Number _____
Group Number _____
Insurance Member (Policy Holder) _____
Birth Date of Member _____
Employer _____

Payment is expected at the time services are rendered, including non-covered portions of insurance.

Our office will request benefit information from your insurance company as a courtesy to our patients. **We do not guarantee the accuracy of benefit information given to us by insurance companies!!! The patient is responsible for knowing what their coverage is for services and materials.** Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your representative. **Please understand that financial responsibility for your account is yours, not your insurance companys'.**

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to either myself or to the party who accepts assignment. I authorize payment of medical benefits to Baxter Eye Care for services and/or materials.

Signed: _____

Relation to patient: _____