Welcome to Puget Sound Eye Care

Please complete the following confidential information. I you would like assistance completing this form, our staff will be happy to help you.

☐Mr. ☐Mrs. ☐Ms. ☐ Miss

Patients Legal First Name _____ MI _____ Last Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip Code _____

Preferred Phone (___) ___-____ Other Phone (___) ___-____

Date of Birth __/__/____ Age _____ Patient's SSN ___-__-____ ☐Male ☐Female

Name of Parent(s) *if patient is a child _____ Person Financially Responsible _____ DOB _____

Emergency Contact Name _____ Phone (___) ___-____ Relationship _____

Email _____ Can we contact you by Email to confirm your appointments or communicate information? ☐Yes ☐No

How were you referred to our office?

☐Phone Book ☐School ☐Advertisement ☐Doctor:
☐Patient ☐Insurance Listing ☐Drive By Name_____
☐Other_____ Phone_____

Insurance Information:

Primary Insurance	Secondary Insurance
Please bring physical insurance card to the appointment. Thank you.	Please bring physical insurance card to the appointment. Thank you.

Payment is expected at the time of service, unless prior arrangements are made with the Billing Department. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any medical information needed to process insurance claims. I authorize my insurance company to make payment directly to the doctor.

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Patient or Patient's Legal Guardian/Representative Date Relationship