LASTER™
EYE CENTER
• AWARD WINNING EYE CARE •

PATIENT INFORMATION FORM

PLEASE UPDATE THE FOLLOWING INFORMATION

NAME _____

ADDRESS _____
STREET CITY STATE ZIP

HOME TELEPHONE _____ CELL _____ E-MAIL ADDRESS _____

DATE OF BIRTH ____/____/____ SOCIAL SECURITY # _____

SPOUSE OR PARENT'S NAME _____ SOCIAL SECURITY # _____

PHARMACY/LOCATION _____

FAMILY DR. _____ PHONE # _____

❑ Please check box if you wish to be contacted via e-mail or text for appointment reminders.

REASON FOR TODAY'S VISIT _____

_____

REFERRING DR./SOURCE _____

EMPLOYMENT INFORMATION

PATIENT'S OR RESPONSIBLE PARTY'S EMPLOYER _____ TELEPHONE _____

OCCUPATION: _____

INSURANCE INFORMATION

MEDICARE # _____

INSURANCE CO. _____ INSURED'S DATE OF BIRTH ____/____/____

ID/POLICY # _____ INSURED'S SSN _____

GROUP # _____ INSURED NAME & RELATIONSHIP _____

VISION INS.: ❑ VSP ❑ EYEMED ❑ SUPERIOR VISION ❑ AMBETTER

INSURANCE AUTHORIZATION AND CONSENT FOR EXAMINATION (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE LASTER EYE CENTER TO GIVE MY INSURANCE COMPANY OR COMPANIES, MY ATTORNEY, OR MY PHYSICIAN, ANY AND ALL INFORMATION THEY MAY REQUIRE CONCERNING MY CASE. I UNDERSTAND AND AGREE I AM RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY MY INSURANCE COMPANY. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COLLECTIONS AND/OR ATTORNEY FEES NECESSARY TO COLLECT THIS DEBIT. ONCE THE ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, A FEE OF 30% OF THE BALANCE DUE WILL BE ADDED TO THE TOTAL. I AUTHORIZE THE DOCTORS AND STAFF OF LASTER EYE CENTER TO EXAMINE MY EYES AND PERFORM ANY SERVICES NORMALLY ASSOCIATED WITH AN EYE EXAMINATION.

_____
(SIGNED) DATE

_____
(RESPONSIBLE PARTY OR PARENT IF PATIENT IS MINOR)