Cates
Family Eye Care
Perfect Vision, Personal Care

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Last Name: _____
First Name: _____
Middle Initial: _____ Sex: ○ Male ○ Female
Tile: _____ Suffix: _____
Nickname: _____
Address Line 1: _____
Address Line 2: _____
City: _____ State: ___ Zip: _____
Home Phone: _____
Daytime Phone: _____
Cell Phone: _____
E-Mail Address: _____
Is it OK to contact you by: ○ E-Mail ○ Text
Referred By: ○ Phone Book ○ Insurance Company
○ Drive By ○ Family ○ Friend
○ Other _____

Date Of Birth: _____
SSN: _____
Marital Status: ○ Married ○ Divorced ○ Single
Employment Status: ○ Full Time ○ Part Time
○ Retired ○ Self Employed ○ Not Employed
Employer: _____
Occupation: _____
** Preferred Language: _____
** **Race:** ○ American Indian ○ Alaskan Native
○ Asian ○ Black/African American ○ Hispanic
○ Multiracial ○ Native Hawaiian/Islander ○ White
Ethnicity: ○ Hispanic ○ Not Hispanic
○ Hawaiian/Islander
** **How would you like to be contacted?**
○ Mail ○ Home Phone ○ Cell Phone ○ Text
○ E-Mail
** We do need all four (4) field filled out, please.

ACCOUNT RESPONSIBLE INFORMATION (the person responsible for payment of account, if different from above).

Name: _____
Address: _____
City: _____ State: ___ Zip: _____
Date of Birth: _____ Relationship: _____
Home Phone: _____ Work Phone: _____

Cell Phone: _____
Employer: _____
Sex: ○ Male ○ Female
SSN: _____

VISION INSURANCE

PRIMARY INSURANCE

Company Name/Medicare/Medicaid/Anthem/ Aetha/ United Healthcare or Other _____
Policy Holder Name: _____
SSN: _____ Date Of Birth: _____

SECONDARY INSURANCE

Company Name: VSP/VSP/Davis/EYEMED/SPECTRA or Other _____
Policy Holder Name: _____
SSN: _____ Date Of Birth: _____

MEDICAL INSURANCE

PRIMARY INSURANCE

Company Name/Medicare/Medicaid/Anthem/ Aetha/ United Healthcare or Other _____

Policy Holder Name: _____

SSN: _____ Date of Birth: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE

Company Name: VSP/VSP/Davis/EYEMED/SPECTRA or Other _____

Policy Holder Name: _____ SSN: _____

Date of Birth: _____

Policy Number: _____ Group Number: _____

FINANCIAL POLICIES: Co-payments are fees not covered by your insurance and are due upon date of service. We will file claims for services rendered to the appropriate insurance payer in good faith. All medical eye care is subject to any insurance deductible. It is the patient's responsibility to know the specifics of the insurance plan and to pay any amounts applied to the patients deductible. and /or co-insurance for non-covered items. A minimum 50% down payment on custom and special order materials is required to start your order. Any balance will be due upon dispensing of your eye wear. Unpaid balances are subject to monthly late fees and additional services fees if sent to collections. NO cash refunds on materials. Canceled orders and returns are subject to penalty fees of up to 50% of original invoice. Materials will be sent back 30 days after notification they have been received by our office and any money paid will be forfeited.

INSURANCE AUTHORIZATION I have read and understood the above policies and authorize payment of insurance benefits from Medicare, Medicaid or other insurance companies to be made on my behave for any optometric services rendered to Cates Family Eye Care, to release any information needed to the appropriate agency to determine any benefits and provide appropriate care.

Signature of Responsible Party: _____ Date: _____

Printed Name: (Printed PDF Only) _____

Notice Of Privacy Policies: By signing below I indicate that I have received or been offered a copy of Cates Family Eye Care Privacy Practices.

Signature of Responsible Party: _____ Date: _____

PRINT SUBMIT