Welcome to Family Vision Care!

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to review/complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Title *(if applicable)*

Email address

First Name | MI | Last Name | Date of Birth | Social Security Number

Mailing Address | City | State | Zip | Cell Phone

Home Phone | Work Phone | Name of Parent or Guardian, if applicable

Emergency Contact Name | Emergency Contact Phone Number

Primary Care Doctor and Name of Office | Preferred Pharmacy Name and Location

Person Responsible for Account | Responsible Party SS# & Date of Birth | Responsible Party Phone Number

Authorization to Release Medical Information

I authorize Family Vision Care to release/request medical information on my behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing.

Please list the name, phone number and relationship of anyone who may have access to your medical information:

Private Health Information

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Family Vision Care's Privacy Policy Notice.

Patient/Guardian Signature _____ Date _____

A copy of this form will be transferred to an electronic format and will be considered as valid as the original.