



EYECARE PROFESSIONALS

2860 S. Alma School Road, Suite 28
Chandler, Arizona 85248
(480) 732-9040 FAX: (480) 782-9579

“Nothing is more precious than your vision”

Established Patient History

Name: (Please Circle) Mr./Mrs./Ms./Dr. _____

Today's Date: ___/___/___/ Phone: _____

Birth date: ___/___/___/ Age: _____ Work Phone: _____

Address: _____

Change in vision insurance? No Yes If yes, type of vision insurance: _____

Please list allergies to Medications: _____

List all medications you take: _____

Are you pregnant and/or nursing: _____

Please list current medical conditions: _____

Please state any problems you are presently having with your vision

Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to EyeCare Professionals, P.C., all changes whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

Responsible party signature: _____

Relationship: _____ **date:** _____