



Welcome to Yin Eyecare

Please complete the following information so that we may provide you better service.

Patient's First Name _____ M.I. _____ Last _____ Suffix _____

Nickname _____ Date of Birth ____/____/____

Parent's Names, if child _____

Home Address _____

City, State, Zip _____

Home Telephone (____) _____ Work Telephone (____) _____ Ext. _____

Cell Phone (____) _____ Email Address _____

I prefer to be contacted by: Home Phone Cell Phone Email Other _____

Emergency Contact Name & Phone _____

How did you find out about our office? _____ If referral, by whom? _____

1. Vision Insurance: Do you have VSP? Yes No If no, please present your vision insurance card card to the receptionist.

2. If you have health insurance, please present your health insurance card. If you do not have vision or health insurance, you may skip the following questions.

3. Do you have secondary vision or health insurance? No Yes If so, please present this insurance card also.

4. Are you a college student? No Yes, full-time Yes, part-time

5. What is your marital status? Single Married Divorced Legally Separated Widowed

*If your insurance is through *your* employer, please proceed to question 8. If not, please answer the remaining questions.

6. What is the patient's relationship to the insured member? Spouse Child Grandchild Other _____

7. What is the insured member's: Full Name _____

Date of Birth ____/____/____

8. Member's employment status is: Employed Full-Time Employed Part-Time Retired Self-Employed
 Active Military Duty Other _____

9. Insured member's employer _____

*Unless we are a participating provider for your insurance plan,
full payment for services is due at the time of the exam.*

Verifying eligibility does not guarantee payment from your insurance company.

Payment in full is required for all materials (glasses and contact lenses) before they are ordered.

I understand that I am responsible for paying my co-payment and any non-covered services, such as contact lens evaluations and fittings, and material fees *today*. If for any reason my insurance company denies payment, the total fee for services and materials is my responsibility. I understand that returned checks will be charged an administrative fee.

Signature _____ Date ____/____/____

(parent or guardian, if minor)

Please present completed forms to the receptionist. Thank you!