PATIENT INFORMATION FOR MINORS OR DEPENDANTS

Date: _____

Primary EyeCare Associates
For a Lifetime of Healthy Vision

Patient Full Legal Name: _____

Male: _____ **Female:** _____

Date of Birth: _____

Address: _____

City/State: _____ **Zip Code:** _____

Home Phone: _____

Cell Phone: _____

E-Mail: _____

Communication Preference:

- ☐ Phone
- ☐ Text
- ☐ Email

Parent(s) or Guardian(s) Information:

#1 Full Legal Name: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

#2 Full Legal Name: _____

Cell Phone: _____

Employer: _____

Vision Ins. Type: _____ **Member Name:** _____

Member DOB: _____ **Member SS #:** _____

Family Physician and/or Specialist: _____

I understand and agree that (regardless on my insurance status), I am ultimately responsible for the balance of my account for any professional services or materials rendered. I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my status of the above information.

Signature: _____ Date: _____
(Parent or Guardian)

Over →