



**WELCOME TO OUR OFFICE  
ADVANCED EYE CARE CENTER**

**Dr. George K. Johnson  
Optometrist**

Date: \_\_\_\_\_

Patients Name: (Mr/Mrs/Ms) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_ Ext \_\_\_\_\_

Social Sec #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_

Who may we THANK for your referral: \_\_\_\_\_

Insurance: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_

Primary Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Relation to Patient: self, spouse, parent, other

List any hobbies, interests: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS/SIGNATURE ON FILE**

I authorize payment of benefits directly to **Advance Eye Care Center** for services rendered. I also authorize release of any medical information that may be required in determination of such benefits.

I understand that some services and procedures may not be covered by my insurance carrier. Fees not paid by my insurance carrier will be my responsibility.

This authorization is in effect until I choose to revoke it.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**I acknowledge I have been offered/received a copy this office's Notice of Privacy Practices.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_