CENTRAL OAHU
EYE CARE

PATIENT INFORMATION

Name: _____ Sex: ◯ Male ◯ Female

Birth Date: _____ Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Address: _____ City: _____ State: _____ ZIP: _____

Email: _____ Preferred Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about us?

◯ I live/work in area ◯ Social media ◯ I was referred by _____ ◯ Other _____

INSURANCE INFORMATION

VISION INSURANCE-PRIMARY

Name of Insurance Company: _____ Policy Holder Name: _____

Member ID: _____ Birth Date: _____ Relationship: ◯Self ◯Child ◯Spouse ◯ Other

VISION INSURANCE-SECONDARY

Name of Insurance Company: _____ Policy Holder Name: _____

Member ID: _____ Birth Date: _____ Relationship: ◯Self ◯Child ◯Spouse ◯ Other

MEDICAL INSURANCE- PRIMARY

Name of Insurance Company: _____ Policy Holder Name: _____

Member ID: _____ Birth Date: _____ Relationship: ◯Self ◯Child ◯Spouse ◯ Other

MEDICAL INSURANCE- SECONDARY

Name of Insurance Company: _____ Policy Holder Name: _____

Member ID: _____ Birth Date: _____ Relationship: ◯Self ◯Child ◯Spouse ◯ Other

I, the undersigned, certify that I (or my dependent) have insurance coverage as written above and assign directly to Dr. Rebecca Cabatbat all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance submissions.

_____ _____

Patient Signature Date