



Welcome to Triad Eye Associates, OD, PA. Thank you for choosing us for your eyecare and eyewear needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions please do not hesitate to ask.

Mr. Mrs. Miss Ms.

Male Female

FIRST NAME	MI	LAST NAME
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STREET ADDRESS	CITY	STATE	ZIP
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SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE	WORK PHONE
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EMPLOYER NAME	SPOUSE OR PARENT'S NAME	EMAIL ADDRESS
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Would you like to receive email from Triad Eye Associates regarding special offers and or events? YES NO

SCHOOL NAME	TEACHER'S NAME	GRADE
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WHAT IS THE MAIN REASON FOR TODAY'S EXAM?

WHEN WAS YOUR LAST EXAM?

How were you referred to our office?

Phone Book
 School
 Advertisement
 Patient (please name) _____
 Insurance Listing
 Drive by
 Other _____
 Doctor (please name) _____

Primary Insurance Information

NAME AND ADDRESS OF PRIMARY INSURANCE COMPANY

INSURED'S FIRST NAME <input type="checkbox"/> M <input type="checkbox"/> F	MI	INSURED'S LAST NAME
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INSURED'S ID NUMBER	GROUP NUMBER	INSURED'S DATE OF BIRTH	EMAIL ADDRESS
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Patient Relationship to Insured

Self
 Spouse
 Child
 Other

Patient Status

Full Time Student
 Part Time Student
 Employed
 Single
 Married
 Other

Secondary Insurance Information

NAME AND ADDRESS OF PRIMARY INSURANCE COMPANY

INSURED'S FIRST NAME <input type="checkbox"/> M <input type="checkbox"/> F	MI	INSURED'S LAST NAME
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INSURED'S ID NUMBER	GROUP NUMBER	INSURED'S DATE OF BIRTH	Patient Relationship to Insured
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Self
 Spouse
 Child
 Other

PLEASE READ In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Triad Eye Associates, OD, PA. I understand that my insurance will be billed as my primary insurance. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Patient Signature _____ Date _____