Welcome To Family Eye Care

2565 Ceanothus Ave, Suite 155, Chico, CA 95973 Tel: 530-899-3939

For faster service, please complete the following form prior to arriving at our office.

Name _____Date_____

Address _____City/State _____ Zip _____

Home Phone _____ Day Phone _____ Cell Phone _____

Birth Date _____Male ☐ Female ☐ SSN _____

Email_____

Employer _____ Occupation _____

Name of Spouse ☐ or Parent ☐ _____

Spouse/Parent's Employer _____

Emergency Contact & Day Phone _____

Who may we thank for referring you to our office? _____

Preferred Language: ☐English ☐Spanish ☐Other

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Hispanic
☐Native Hawaiin/Pacific Islander ☐White

Ethnicity: ☐Hispanic/Latino ☐Native Hawaiin/Pacific Islander ☐Not Hispanic/Latino

Preferred Communication: ☐Email ☐Postal ☐Telephone

Medical Insurance Information

Name of Insured Person _____ Relationship to Patient _____

Address of Insured Person _____

Birth Date _____ SSN _____

Insurance Company _____Insurance ID #_____ Group # _____

I acknowledge that I have read or been given the opportunity to read Family Eye Care's Notice of Privacy Practices (available at the front desk).

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I request that payment of insurance benefits be made on my behalf to Family Eye Care Optometry for any services and materials furnished. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date _____