

**Family Eyecare of Roswell**

1425 Market Blvd; Suite 315

Roswell, GA 30076

(770) 992-6789

**INSURANCE INFORMATION**

The following information must be provided in order for us to accept and file vision insurance. Please complete all fields. You will be asked for a copy of your insurance card if applicable.

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Sex: Male Female

City, State, Zip: \_\_\_\_\_ Soc Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_ Insurance ID# (If different from above):

Employer: \_\_\_\_\_

**Insured's Information:** (Please complete only if you are a dependent on another's insurance policy)

Relationship to insured: Spouse Child Other

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Soc Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

City, State, Zip: \_\_\_\_\_ Sex: Male Female

Telephone #: ( ) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance ID# (If different from above):

Office Use Only:

Insurance Plan: \_\_\_\_\_ Authorization # \_\_\_\_\_

Authorization Date: \_\_\_\_\_ Authorized by \_\_\_\_\_