PATIENT INFORMATION

Personal

Name ___________________________________ Social Security #_______________________

Driver's License Number__________________________ Birth Date ____________________

Address ____________________________________ City _____________________________

State __________ Zip Code ___________ Home Phone ____________________

Business Phone _______________________ Cell Phone _________________________

Name of Parent or Spouse ________________________ E-mail ______________________

Have we examined other members of your family? _____ Yes _____ No

If yes, whom? ____

Employment

Occupation _____________________________ Employer ______________________________

Grade if Student ___________ School ____

Do you use a computer? _____ No _____ Yes: How many hours per day? ______________

Method of Payment

Medicare ___ Medicaid ___ Check ___ Cash ___ Credit Card ___

Vision Service Plan ___ Superior Vision ____ Other Insurance ______________________

Medical and/or Vision Insurance

Insurance Company_______________________ Policy Number _______________________

Medicare Number ________________________ Medicaid Number_____________________

Supplemental Insurance ___________________ Policy # ____________________________

Name & Address of Family Physician

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Name & Address of Last Eye Doctor

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How Did You Find Out About Our Office?

Yellow Pages ___ Location ___ Radio ___ Family Doctor ___

Newspaper ___ Mailouts ___ Television ___ Insurance Company ___

Referred By: (name) ____

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