Welcome

PLEASE PRINT CLEARLY

Patient Information

Patient Name:

Address:

City:

State: Zip:

Date of Birth:

Sex: Male Female

Marital Status: Single Married Other

Employment Status: Employed Student Retired Other

Occupation:

Patient Social Security #:

Primary Care Physician:

Activities

Special Visual Needs:

Hobbies:

Are you interested in contact lenses? Yes No

Are you interested in laser vision correction? Yes No

Alcohol Consumption: Never Rarely Moderately Daily

Daily Tobacco Use: Never Yes Previous

Contact Information

Home Phone:

Cell Phone:

Email:

Insurance Information

*Please complete all applicable information

Primary Medical Insurance:

Primary Insurance Holder (PIH):

Relationship to Patient (Please Circle): Self Spouse Child Other

PIH Date of Birth:

PIH Social Sec. #:

Primary Vision Insurance:

Primary Insurance Holder (PIH):

Relationship to Patient (Please Circle): Self Spouse Child Other

PIH Date of Birth:

PIH Social Sec. #:

Secondary Medical Insurance:

Primary Insurance Holder (PIH):

Relationship to Patient (Please Circle): Self Spouse Child Other

PIH Date of Birth:

PIH Social Sec. #:

Secondary Vision Insurance:

Primary Insurance Holder (PIH):

Relationship to Patient (Please Circle): Self Spouse Child Other

PIH Date of Birth:

PIH Social Sec. #:

Assignment and Release I, the undersigned, assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to realize all information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Date