PLEASE PRINT

Date: _____ Name: _____

Date of birth: _____ Male _____ Female _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work : (___) _____

Email :_____ Employed _____ Retired _____ N/A _____

Please list employer: _____

Employer address: _____ City: _____ State: _____ Zip: _____

Circle One: Single Married Widowed Divorced Student Social Security #: _____

Spouse/Parent or Guardian: _____ Is Spouse/Parent/Guardian Employed? Yes No

If employed, please list name of employer: _____ Work # _____

Spouse/Parent/Guardian Social Security # _____ Spouse/Parent Guardian Date of Birth: _____

Friend or relative not living with you: _____ Phone (___) _____

Family doctor: _____ City, State: _____

Did an Optometrist request you be seen here? Yes____ No ____ If so, please list:_____

INSURANCE INFORMATION

Primary Insurance: _____ Policy holder: _____ Their date of birth: _____

Is this plan through an employer? Yes ____ No ____ If so, please list: _____

Does this plan require a referral from your primary care physician? Yes ____ No____

Secondary Insurance: _____ Policy holder: _____ Their date of birth:_____

Is this plan through an employer? Yes ____ No ____ If so, please list: _____

Does this plan require a referral from your primary care physician? Yes ____ No____

I agree that the above information is true

Signature of Patient/Responsible Party

Sign here: _____

FILL OUT ONLY IF YOU ARE A NEW PATIENT

How did you hear about our office? _____

____ Radio ____ Screening ____ Yellow Pages ____ Internet ____ Doctor (please list below)

____ Relative or friend (please list below) ____ Newspaper ____ Other (please list) _____

Name of friend/relative or referring doctor: _____

Address: _____ Phone: _____