

**PLEASE PRINT CLEARLY** **PERSONAL INFORMATION**

Patient Name Last First MI Social Security No.

Patient Address Street City State Zip Code

Patient Email

Date of Birth Sex Marital Status M F S M D W

Referring Doctor Address Medical Doctor (if other than referring doctor) Address

Patient Telephone Number Work Telephone Number Cell Phone Number

Person Responsible for Payment Address (if other than patient address)

Contact in Case of Emergency Name Relationship to Patient Telephone Number

Regardless of the insurance coverage or workers' compensation coverage I have, I agree I am ultimately responsible for the bill. If my account requires collection service, I realize I will be responsible for any collection costs.

Signature Date

**INSURANCE INFORMATION**

Vision Insurance Co. Medical Insurance Co.

Subscriber's Name Subscriber's Sex Relationship to Patient

Subscriber's Birthdate Subscriber's Social Security Number

Subscriber's Employer Employer's Telephone Number

ID # Group/Account #

Please present your health insurance cards so we can make a copy for our records. If you have no health insurance check here \_\_\_\_\_

**OFFICE INFORMATION**

*Please tell us how you heard about our practice*

- Family doctor (Dr. \_\_\_\_\_) referred me. (2) Yellow Pages (1)
Another eye doctor (Dr. \_\_\_\_\_) referred me.(2) Friend or relative (3)
Internet (4) Insurance company (5)
Hospital (6) Newspaper (7)
Other (8)\_\_\_\_\_