Date ______________________

Patient Name ____ Birth Date __________________________
(last) (first) (middle) month / day / year

Gender: ____ Male ____Female SS# ___________________________

Address: ____
(apt) (city) (state) (zip)

Home Telephone: _____________________________ Cell Phone: _____________________________

Business Telephone: ___________________________ Occupation: ____________________________

Email: _____________________________________ (for practice correspondence only)

Preferred contact method (practice related correspondence only): _____ Email _____ Phone _____Text

Pharmacy Information: ____
(name) (telephone)

Person to notify in case of Emergency: ____
(name) (relation) (telephone)

Referred by:

Family/Friend ________________________________ Online/Ad/Media ____________________________

Physician ____

My Primary Care Doctor: ____
(name) (telephone)

My Eye Care Provider: ____
(name) (telephone)

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Company: ____

Name of Subscriber & Relationship: ____

Date of Birth of Subscriber : _________________
month / day / year

Policy ID & Group Number: ____

SECONDARY INSURANCE:

Insurance Company: ____

Name of Insured & Relationship: ____

Policy ID & Group Number: ____