

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to help you. We look forward to working with you in maintaining your health.

Patient Information

Name _____ Date ____/____/____
LAST NAME FIRST NAME INITIAL

Address _____ Soc. Sec. # _____

City _____ State _____ ZIP _____ Phone _____

Sex M F Age _____ Birth Date ____/____/____ Single Married Widowed Divorced

Patient Employed by _____ Occupation _____

Business Phone _____ Email _____

Account Responsible

If different from above

Person Responsible for Account _____
LAST NAME FIRST NAME INITIAL

Relation to Patient _____ Birth Date ____/____/____ Soc. Sec. # _____

Address (if different from patient) _____

City _____ State _____ ZIP _____ Preferred Phone _____

Health Insurance Information

Many eye problems are covered by your Health Insurance

Health Plan _____ Phone _____

Subscriber # _____ Group # _____ Effective Date _____

Subscriber's Name _____ Relation to Patient _____ Birth Date _____

Subscriber Employed by _____ Business Phone _____

Do you have a deductible to meet? _____ Deductible amount _____

Vision Plan Information

Vision Plan _____ Phone _____

Subscriber # _____ Group # _____ Effective Date _____

Subscriber's Name _____ Relation to Patient _____ Birth Date _____

Subscriber Employed by _____ Business Phone _____

When was the last time this patient used his/her vision plan benefits? _____