PATIENT INFORMATION

Personal

Name ______________________ Social Security # ______________________
Driver's License Number______________________ Birth Date ______________________
Address______________________ City ______________________
State __________ Zip Code ___________ Home Phone ______________________
Business Phone ______________________ Cell Phone ______________________
Name of Parent or Spouse ______________________
Have we examined other members of your family? _____ Yes _____ No
If yes, whom? ______________________

Employment

Occupation ______________________ Employer ______________________
Grade if Student ___________ School ______________________
Do you use a computer? _____ No _____ Yes: How many hours per day? ______________

Method of Payment

Medicare ___ Medicaid ___ Check ___ Cash ___ Credit Card ___
Vision Service Plan ___ Superior Vision ____ Other Insurance ______________________

Medical and/or Vision Insurance

Insurance Company______________________ Policy Number ______________________
Medicare Number ______________________ Medicaid Number______________________
Supplemental Insurance ___________________ Policy # ______________________

Name & Address of Family Physician
____
____
____
____

Name & Address of Last Eye Doctor
____
____
____
____

How Did You Find Out About Our Office?

Yellow Pages ___ Location ___ Radio ___ Family Doctor ___
Newspaper ___ Mailouts ___ Television ___ Insurance Company ___
Referred By: (name) ______________________

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