

PATIENT INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_
Residence \_\_\_\_\_
Mailing Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Home Phone ( ) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_
Birth Date \_\_\_\_\_ Marital Status S M W D
Social Sec. # \_\_\_\_\_
Employer \_\_\_\_\_
Mailing Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Work Phone ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Pager \_\_\_\_\_
Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_
Primary Care / Referring Physician \_\_\_\_\_
What Insurance do you have? \_\_\_\_\_
Name of Insured \_\_\_\_\_ Social Sec. # \_\_\_\_\_

<> Please show your insurance card to the receptionist when you check in <>

PARENT or LEGAL GUARDIAN of PATIENT

Name \_\_\_\_\_ Date \_\_\_\_\_
Residence \_\_\_\_\_
Mailing Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Home Phone ( ) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_
Birth Date \_\_\_\_\_ Marital Status S M W D
Social Sec. # \_\_\_\_\_
Employer \_\_\_\_\_
Mailing Address \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
Work Phone ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Pager \_\_\_\_\_

I have read and understand the Eye Care Center Financial Policy on the back of this page.

\_\_\_\_\_  
Patient Signature (or Responsible Party) Date