Patient Information

Last Name: ______________________ **First Name:** ______________________

Address: ____
Street *APT.* *City,* *State* *ZIP*

Date of Birth: ____/____/____ **Social Sec. #:** ______________________

Telephone: *Home #:* (____)__________ *Cell #:* (____)__________ *Work #:* (____)__________

Emergency #: (____)______________ *Fax #:* (____)______________

Sex: *Male:* ___ *Female:* ___ **Marital Status:** *Single:* ___ *Married:* ___ *Divorced:* ___ *Other:* ___

Email Address: ____

Employer Name & Address: ____

Insurance Information

Primary Insurance: ______________________ **Policy#:** ______________________

Subscriber: *Self* ___ *Parent* ___ *Spouse* ___ *Other* ___

(If other than self) Subscriber Name: ____
Last *First*

Subscriber's D.O.B: ____/____/____ **Subscriber's Social Sec. #:** ______________________

Subscriber's Address: ____

Secondary Insurance: ______________________ **Policy#:** ______________________

Medical Information

What brings you to our office today? ____

Who may we thank for referring you? ____

Check all that apply:	**Personal History**	**Family History**
Glaucoma	___	___
Eye Surgery	___	___
Frequent Eye Infection	___	___
Allergies/Sinus Problems	___	___
High Blood Pressure	___	___
Diabetes	___	___
Other (Please Explain)		

List any medications you are currently taking: ____

List any medications you are allergic to: ____

Preferred Language:	*English* ___ *Spanish* ___ *French* ___ *Other* ___
Race:	*African American* ___ *Hispanic* ___ *Caucasian* ___ *Asian* ___ *American Indian* ___ *Native American* ___ *Other* ___
Ethnicity:	*Black* ___ *Hispanic* ___ *Asian* ___ *Other* ___
Preferred Contact #'s: *(Check all that apply)*	*Home Phone:* ___ *Cell Phone:* ___ *Work Phone:* ___

Physician's Name: ______________________ **Physician's phone #:** (____)______________

Physician's Address: ____

I certify that the above questions have been answered accurately to the best of my knowledge. I authorize the eye doctor to release any information necessary during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services on my behalf or my dependents.

Signature of Patient (or parent if minor): X______________________ ***Date:*** ____/____/____