Patient Information Sheet

Today's Date: ____________

Mr.,Mrs.,Ms. ______________________ ______________________ _____ M F
(Last Name) (First Name) (MI) (Sex)

Address ______________________ ______________________ _____ _______
(City) (State) (Zip Code)

(____)______________ (____)______________ _______-______-_______
(Home Phone) (Cell Phone) (Birth Date)

_______-______-________ EMAIL: ______________________
(Social Security #)

Employer's Name: ______________________ (____)______________
(Work Phone)

Referred By: ______________________

Spouse (Name) ______________________ Date of Birth ______________

Employer ______________________ Work Phone ______________

Social Security __________(Last 4 Digits) Cell #: ______________

Responsible Party Information (If different than above)

Name ______________________ Relationship to Patient ______________

Address______________________ Social Security ______________

______________________ Date of Birth______________

Home Phone ______________________ Driver's License ______________

Employer______________________ Work Phone ______________

Insurance Information

Name of Vision Insurance: ______________

MEDICAL
Primary:______________________

Secondary: ______________________

Please Note: As a courtesy, our office will bill your insurance. However you will be responsible to pay for services rendered, unless other arrangements are made in advance. If your insurance requires prior authorization, it is the patient's responsibility to ensure that is obtained before each visit.

Signature:______________________ Date: ______________
(Patient / Guardian)