# Patient Information Sheet

_____ _____ _____

(Last Name) (First Name) (MI)

Date of Birth____/____/____ gender: (M) ( F)

Address_____Apt/Sp#_____

City_____St_____ Zip Code_____

Phone (cell)_____(home)_____

SS#_____-_____-_____ E-Mail_____

Employer_____Occupation_____

Spouse_____ Date of Birth___/___/_____ Last 4 SS#_____

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**Responsible Party (Guarantor if different from above)**

Name_____ Relationship to Patient _____

Address_____ Apt/Sp#_____

City_____St_____ Zip Code _____

Date of Birth____/____/_____SS#_____-_____-_____

**Insurance Information**

Vision_____

Medical_____ Secondary_____

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**Please note as a courtesy, our office will bill your insurance. However, you will be responsible if your insurance does not cover services or materials.**

Signature_____ Date_____

Patient/Guardian