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#_____

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**_____

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