The Center for Eye Care and Optical

PATIENT INFORMATION FORM

Patient Legal Name: _____

Gender: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Preferred Phone: _____ Type: ☐ Home ☐ Cell ☐ Work

Backup Phone: _____ Type: ☐ Home ☐ Cell ☐ Work

Prefer Text? ☐ Yes ☐ No OK to Leave Voicemail? ☐ Yes ☐ No

Email Address: _____

Emergency Contact Name: _____

Relationship: _____ Emergency Phone: _____

PHYSICIAN INFORMATION

Primary Care Physician: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Payer: _____

Policy Number: _____ Group Number: _____

Policyholder (if different): _____

Secondary Insurance Payer (if any): _____

Policy Number: _____ Group Number: _____

Policyholder (if different): _____

VISION INSURANCE INFORMATION

Vision Insurance Payer: _____

Policy Number: _____ Group Number: _____

Policyholder (if different): _____

Is Your Condition Related to: ☐ Employment ☐ Auto Accident

I acknowledge that the above information is complete and correct. I accept financial responsibility for any services rendered for my dependent or myself.

Signature: _____ Date: _____