EYE CARE & SURGERY, P.C.

****NOTE****

1) PLEASE PRESENT CURRENT INSURANCE CARD TO RECEPTIONIST

2) IF YOU HAVE A VISION PLAN WITH WHICH WE PARTICIPATE AND YOU WISH TO UTILIZE IT, YOU MUST COMMUNICATE THIS AT THE CHECK-IN DESK *BEFORE* BEING SEEN FOR YOUR APPOINTMENT.

PLEASE COMPLETE ALL INFORMATION:

Date _____

Name _____ Sex: M F Date of Birth _____
Last First Middle

Social Security Number _____ Home Phone ( ) _____

E-Mail Address _____ Cell Phone ( ) _____

Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

For future use, what is your preferred method of communication? [ ] Phone [ ] Text [ ] E-mail

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed

Employer _____ Business Phone ( ) _____

***NAME OF PERSON WHO HAS INSURANCE POLICY** _____

***MUST HAVE DATE OF BIRTH OF PERSON WHO HAS INSURANCE POLICY** _____

***SOCIAL SECURITY # OF PERSON WHO HAS INSURANCE POLICY** _____

Name of Primary Care Physician _____

SPOUSE OR PARENT INFORMATION:

Name _____ Relationship to patient _____

Address _____ Phone ( ) _____

Employer _____ Business Phone ( ) _____

Contact in case of emergency, if different _____ **Phone** _____

NAME OF PERSON WHO REFERRED YOU TO US:

Doctor _____ Other _____

Family Member (name) _____ Relation to you _____

Friend (name) _____

OTHER (CIRCLE ONE) - Newspaper - Phone Book - Internet - Radio