PATIENT INFORMATION

Patient Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ □ Male □ Female

Marital Status: Single Married Divorced Widowed Separated

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

□ SPOUSE □ PARENT (if minor) □ LEGAL GUARDIAN INFORMATION (Please check one)

Name: _____ Date of Birth: _____/_____/_____ Age: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ Occupation: _____

FINANCIALLY RESPONSIBLE PARTY

Name: _____ Date of Birth: _____/_____/_____ Age: _____ SS #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ Occupation: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

DOCTOR/VISIT INFORMATION

Referred By: _____ Primary Care Doctor: _____

Reason for Visit: _____ **Are you interested in LASIK? YES NO**

Work Related Injury? YES NO Date of Work Related Injury: _____/_____/_____

PHARMACY NAME: _____ **PHONE NUMBER: (_____)**_____

INSURANCE INFORMATION

Primary: _____ Name of Policy Holder: _____

Policy Holder Date of Birth: _____/_____/_____ Relationship to Patient: _____ SS #: _____

Secondary: _____ Name of Policy Holder: _____

Policy Holder Date of Birth: _____/_____/_____ Relationship to Patient: _____ SS #: _____