Eye Physicians and Surgeons

Patient Information Form

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Personal Information						
First Name:	M.I.:	Last Name:		Birth Date:	Sex: **M F**	Marital Status: **S M W D**
Street Address:				Home Phone #:		
City:		State:	Zip:	Work Phone #:		
Email Address:		Social Security #:		Cell Phone #:		
Name of Employer:		Employer Address:			Occupation:	
Parent or Guardian Information: (For Minors)						
Full Name:			DOB:	Home Phone #:		
Address:				Social Security #:		
Insurance Information (PLEASE PRESENT CARDS)						
Primary Insurance Company Name:			Subscriber # or ID #:		Group #:	
Subscriber Name:			Subscriber Date of Birth:		Subscriber is: **Spouse Parent**	
Secondary Insurance Company Name:			Subscriber # or ID #:		Group #:	
Name of Spouse:	Spouse DOB:		Spouse Social Security #:		Do you have VSP, VCP, or VBA vision plan? **YES NO**	
Other Information						
In Case of Emergency, Please Contact:			Contact's Relationship to Patient:		Contact's Phone #:	
Who referred you to our office for examination?						

By signing below, I authorize this office to release any information to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage. I also authorize this office to provide me with reasonable and proper medical care by today's standards.

Signature (Patient/Legal Guardian): ____________________________ **Date:** ________________