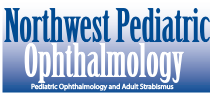

Adult Patient Information

PLEASE PRINT

NAME ______________________ Nickname ______________ **SEX** ❑ M ❑ F
Last First MI

ADDRESS ____
Street Address/PO BOX # City State ZIP

PREFERRED PHONE(______) ____________ **SECONDARY PHONE**(______) ____________ OK to call these numbers and leave message? YES NO

PATIENT AGE ________ **BIRTH DATE** ______________

EMERGENCY CONTACT ______________________ **PHONE #** (______) ____________

PRIMARY DOCTOR

____

PCP Clinic Name ______________________

Address ______________________
Street Address/PO BOX

____
City State ZIP

Phone #(______) ______________

If patient was referred, by whom?

____

IS THIS YOUR:
❑ **Primary caregiver** ❑ **Regular Eye Doctor**
❑ **Other** ____________

EMPLOYER ______________________ OCCUPATION ______________________

EMPLOYER PHONE # ______________________ OK to call this number? ______________

Person responsible for bill: ______________________ **SS#** ______________

PHONE # (______) ____________ ADDRESS ______________________
Street Address/PO BOX # City State ZIP

INSURANCE INFORMATION (MUST BE COMPLETED IN ADDITION TO OBTAINING A COPY OF YOUR CARD)

Primary Insurance: ______________________ Policyholder's Name ______________________

Secondary Insurance: ______________________ Policyholder's Name ______________________

Assignment of Benefits: I hereby assign to the physician all payments for medical services rendered to my dependents. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all the charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient Signature ______________________ **Date** ______________

Reviewed ________ ________ ________ ________ ________ ________
Date Date Date Date Date Date