FULL NAME: _____
LAST FIRST MIDDLE

SEX: ❑ MALE ❑ FEMALE BIRTHDATE: _____/_____/_____ AGE: _____

PT: SOCIAL SECURITY #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Occupation:_____

CHECK APPROPRIATE BOX: ❑ Minor ❑ Single ❑ Separated ❑ Married ❑ Divorced ❑ Widowed

REFERRED BY:
❑ DR._____
❑ FRIEND ❑ YELLOW PAGE ❑ TV
❑ RADIO ❑ NEWSPAPER ❑ OTHER

PATIENT ADDRESS: _____
NUMBER STREET

_____
CITY STATE ZIP

PATIENT EMPLOYER: _____ PATIENT'S WORK PHONE:_____

PATIENT HOME PHONE: _____ EMERGENCY PHONE:_____

EMERGENCY CONTACT NAME:_____ RELATIONSHIP:_____

RESPONSIBLE PARTY NAME:_____
LAST FIRST MIDDLE

RESPONSIBLE PARTY ADDRESS: _____
NUMBER STREET

_____
CITY STATE ZIP

RESPONSIBLE PARTY PHONE:_____ NAME:_____ RELATIONSHIP:_____

FAMILY PHYSICIAN:_____

OPTOMETRIST:_____

SPOUSE NAME:_____

SPOUSE EMPLOYER:_____

SPOUSE WORK PHONE:_____

INSURANCE INFORMATION
PLEASE HAVE YOUR INSURANCE CARDS READY FOR US TO COPY

1. **PRIMARY INSURANCE COMPANY: NAME** _____

   POLICY HOLDER: _____ POLICY NUMBER: _____

   GROUP NUMBER: _____

2. SECONDARY INSURANCE COMPANY: NAME _____

   POLICY HOLDER: _____ POLICY NUMBER: _____

   GROUP NUMBER: _____

3. DO YOU HAVE ADDITIONAL INSURANCE? ❑ Yes ❑ No